

THE MEDICAL JOURNAL OF AUSTRALIA.

Vol. II.—2ND YEAR.

SYDNEY, SEPTEMBER 11, 1915.

No. 11.

NOTES ON MALIGNANT DISEASE OF THE LOWER BOWEL.¹

By E. T. Thring, F.R.C.S. (Eng.),
Sydney.

I purpose placing before you this evening notes on three cases of malignant disease of the lower bowel. The three cases are all recent ones, having come under my notice between July 30 and August 19. They are not in any sense unique or possessed of any very special features of interest. At the same time they are such as demand from the general practitioner and the surgeon careful consideration, in order to obtain the best possible results for the patients who suffer from intestinal carcinoma.

1. L. R., aged 53 years, unmarried, has complained for years of "indigestion," and of late years has suffered from somewhat obstinate constipation, becoming noticeably worse during the last twelve months. On July 23 a rather sudden attack of severe pain in the lower abdomen occurred. After the bowels were relieved, the pain became less, and no further notice was taken. During the following five days, the patient, while not feeling herself, was not sufficiently ill to make her call in a medical man. On the sixth day, early in the morning, very severe pain was again complained of. Dr. Mawson, of Campbelltown, saw the patient, found her very ill, evidently suffering from some serious abdominal condition. She was seen by me the same day, at about 11.30, when she was conscious, looked very ill and sunken about the eyes. Her temperature was subnormal, and pulse-rate 120; she was very feeble, and the whole abdomen was distended and very tender.

It was obvious that an abdominal catastrophe had happened, and that the patient was extremely ill; both Dr. Mawson and I agreed that her chances of recovery were absolutely nil if left alone, and but small if an operation were done. Taking into consideration the previous history of long-standing indigestion, it was thought possible that there might be a perforation of the stomach or duodenum.

An incision was made in the upper abdomen, and the whole peritoneal cavity was found full of pus, smelling of *bacillus coli communis*. No perforation of the stomach or duodenum was discovered. The appendix was then examined and found to be club-shaped, but not perforated. It was removed, although it was evident that there was other cause for the septic peritonitis. The transverse colon and the descending colon were found to be distended, and on following the gut downwards the real source of trouble was discovered. There was a ring carcinoma of the pelvic colon, just above the pelvic floor. The gut had perforated here, probably the first leak having taken place at the time of the first attack of pain, six

days previously. Presumably, the leak was a small one, and had been temporarily closed by lymph; the peritoneal cavity had become infected, gradually resulting in the condition of general septic peritonitis found at the time of operation. The patient's condition was so bad that nothing more could be done but closure of the abdomen. She died the same evening.

2. H.F., male, aged 65 years. The history was that some two years ago there was a severe attack of "colitis." The patient was very ill at the time, but recovered. For the past few months he had been suffering from increasingly obstinate constipation, and had been losing weight. There had been muco-pus and blood passed *per anum*. His home is in New Zealand, where he had been examined under an anæsthetic, and told that he had a growth in the lower bowel.

I saw him after his arrival in Sydney, and, on examination, it was easy to feel an elongated mass, rising out of the pelvis, on the left side. This appeared to me to consist, to a great extent, of faecal accumulation in the pelvic colon. On rectal examination, the mass could be felt above the level of the pelvic floor. A diagnosis of carcinoma of the pelvic colon was made.

Operation, August 16.—An incision was made from above the pubes on the left side of the middle line, extending to above the level of the umbilicus. The rectus sheath was divided, the muscle turned outwards and the peritoneal cavity opened. Dense and very extensive adhesions, involving the whole of the pelvic colon and a portion of the great omentum, were found, as well as a mass of new growth in the sigmoid, extending down, apparently, nearly to the pelvic floor.

The adhesions were carefully separated, the colon mobilized from the splenic flexure, right down to the pelvic floor. The sigmoid branches of the inferior mesenteric artery were ligatured and divided. The colon was then divided above the level of the pelvic brim, and also below the growth, leaving about one inch of gut, apparently free from disease, above the pelvic floor. The excised portion of intestine, together with its mesentery, was removed.

Had the patient's condition permitted, a permanent colostomy would have been done, and the whole of the gut down to the anus, together with the contents of the ischio-rectal fossæ, removed. This, however, was not advisable, and it seemed wiser to anastomose the divided ends of the gut. This was done by means of a Murphy's button. A split rubber drainage tube, with iodoform gauze inside it, was introduced, the lower end being placed just behind the anastomosis. The incision was then sutured and the abdomen closed.

My reason for using the drainage tube was that at the point of anastomosis the lower portion of the

¹ Read at a meeting of the New South Wales Branch of the British Medical Association on August 27, 1915.

gut was only covered by peritoneum on the anterior surface, and I therefore feared a leak.

The patient's subsequent progress has been surprisingly good; in fact, he looks better already than before the operation, the bowels being freely and repeatedly relieved *per anum*. The wound has united by first intention, excepting where the drainage tube lay, and so far there has been only one slight leak of what appeared to be faecal material along the track of the drainage tube; there has been no leak during the last three days. The Murphy's button has not yet been passed, and therefore I do not feel certain that there may not be a further leak. In any case, the probability is that whatever opening in the wall of the gut there may be, it will close spontaneously.

On examining the specimen removed, you will see that there is plenty of healthy intestine above the new growth. Below the growth, the section is closer to the tumour than I like. I must, however, point out that another inch of what appeared to be normal gut must be added to the specimen before the lower end is reached. This was removed separately from the main mass.

The operation done, while not to my mind an ideal one, seemed to me the best that could be done under the conditions existing. While, as I said before, I should like to have extirpated the whole of the rectum, including the anus, I feel sure that the patient would not have survived the necessary extra manipulation. As the specimen shows, the whole of the lymph tracts leading upwards and into the glands which lie along the branches of the inferior mesenteric artery have been removed, and as the lower segment of gut was apparently not involved by the growth, there is, I believe, a very fair chance of non-recurrence. The patient, also, has been saved the disadvantage of a permanent colostomy. I quite feel that the operation done is open to criticism, but I also believe that, in this particular instance, it was the wiser course to follow.

There has been no suppuration, excepting along the drainage track, and only on the day following operation did the temperature reach 99.6°. From that time onward it has been normal.

3. Mrs. G., aged 58 years, the mother of several children, first noticed troublesome constipation about two years ago. This was followed later by discharge of mucus and blood *per anum*, which the patient attributed to piles. Finding her discomfort increasing, and also that she was losing weight, she came to Sydney six months ago, and saw a surgeon, who proposed an operation. This the patient refused, and returned to her home in the country. She was seen by Dr. Gaden on August 14, who found her suffering from somewhat advanced rectal carcinoma. I saw her with him on the following day, and we operated on August 19. In this case the growth was placed absolutely in the rectal portion of the gut, commencing just above the internal sphincter, and extending upwards towards the pelvic floor.

The patient was thin, wasted, and not in such a condition as to withstand the shock of a prolonged

intra-abdominal operation. It appeared wise to adopt an entirely different method of procedure in this case to that which was followed in the last case. An inguinal colostomy was done first, the gut being secured in position, but not opened. Then the patient was placed in the semi-prone position, on her right side, and the incision recommended by Ernest Miles was made, that is, transversely, about four inches, at the level of the junction between sacrum and coccyx. It was then continued in the inter-natal fold to about an inch and a quarter from the anus, encircling the anus on each side a full inch wide of it, and then along the middle line forward, stopping short of the vulval orifice. The anus was closed by a purse-string suture. The transverse incision was deepened to the sacro-coccygeal articulation, the coccyx separated and coccygeal muscles divided and the soft tissues in front of the sacrum stripped up. The gut was separated from the vaginal wall in front, and the ischio-rectal fossae cleaned out. The gut was freed up to the pelvic floor, the pelvic fascia and *levator ani* divided near the pelvic walls, as well as the lateral rectal ligaments, and with them the middle hæmorrhoidal vessels. The peritoneum of Douglas' pouch was stripped up from the rectum. In doing this the peritoneal cavity was opened and the gut freed still further up into the pelvis, all the soft tissues being taken out. It was then divided and the upper end closed. The lower segment of gut with the growth and anus was removed. This left a portion of the sigmoid with a closed end below the site of the colostomy.

The cavity left by this dissection and removal of gut was a large one; and could not possibly be closed by suture, so that while the greater portion of the skin incision was sutured, the portion which surrounded the anus was left open and the cavity packed by iodoform gauze, contained in a layer of oiled silk.

The specimen shows that one had gone wide of the original growth, but, of course, the ideal operation would have been much more radical, that is, the removal of gut from inside the abdomen, as was done in the case of J.F., finishing by a complete removal of the rectum from below.

In this case, however, both Dr. Gaden and I judged that the patient would not stand such a prolongation of the operation, and an examination of the specimen removed shows that she has at all events a fair chance of non-recurrence. The colostomy was completed on the third day by opening the gut.

The patient's condition to-day is good, and the huge cavity left by the operation is already closing up rapidly.

I have brought these cases before you to-night because they are such as any one of us might encounter at any time. It is only of late years that anything like a radical treatment of carcinoma of the lower gut has been attempted. We may, I think, say truly that the treatment of malignant new growth in any organ must be decided by the distribution of the lymphatic vessels and glands in connexion with that organ. This has been carried out in connexion with the breast and the uterus for many

years past, and more recently these principles have been applied to the various portions of the alimentary tract.

My own feeling is that the cases I have placed before you to-night are, in effect, an admission of failure, for it is perfectly evident that neither of the operations was ideal. On the other hand, one must "cut one's coat according to one's cloth," and it appeared to me to be better to be satisfied with a living patient who has, I may now say, a certainty of a fairly comfortable existence for a considerable length of time, and a possibility of non-recurrence of the growth, than to have completed a more radical procedure with vastly increased immediate risk to the patient.

Again, such cases as these emphasize the great importance of early diagnosis, associated with early and radical operation. This was borne in upon me twenty years ago, in connexion with carcinoma of the uterus, and if only one can obtain, in connexion with new growths of the gut, as good results as can be obtained in carcinoma of the uterus by early and radical operation, we shall be doing good work.

I shall be only too pleased if you will criticize what I have said and done, as I feel I have very much to learn yet.

I should like to digress for a few minutes. A short time ago I placed before you the notes on five cases of gall-bladder surgery, and one of my comments was, that I rather expected there might be trouble in connexion with one of the cases, in which I drained, but did not excise the gall-bladder. I regret to say that I was justified in my comment, and that trouble did ensue in this particular instance.

At the time I likened the previously infected gall-bladder which had been drained, and in which the drainage opening had closed, to a "stagnant pool," which might cause trouble later on. In the case to which I am referring the drainage tube opening closed, and, apparently, the valve-like fold of mucous membrane which lies between the neck of the gall-bladder and the cystic duct became swollen, and blocked the exit of septic bile from the gall-bladder. The patient became very ill as the result of septic absorption. I re-opened the gall-bladder and dilated the cystic duct, without placing the patient under an anæsthetic. This, combined with irrigation of the gall-bladder and ducts by normal saline solution, put an end to the trouble. The drainage opening into the gall-bladder has now closed, I trust finally, and the patient is very well indeed. Still I feel some misgiving, for may not the same condition recur? Had I excised the gall-bladder, this would not have happened.

SUMMER CLOTHING FOR SYDNEY.¹

By F. Guy Griffiths, M.D.,

Honorary Physician, Royal North Shore Hospital of Sydney;
Honorary Physician, Anti-Tuberculosis Dispensary of the National
Association for the Prevention and Cure of Consumption.

I fear that you may find this subject unseasonable, and, further, I must apologise for the inelegant

manner in which the matter is put together, my excuse being that I composed the paper hurriedly, at the request of our Honorary Medical Secretary, who found himself short of material for to-night's meeting.

Clothing for summer wear in Sydney should be selected for comfort, not for style. It should be at once light, airy and loose fitting. As regards lightness, we are faced with a difficulty: cotton, linen and silk are beautifully light, but afford scant protection against the cold southerlies which come up so unexpectedly and produce so sudden and marked a fall of temperature. They have the further disadvantage of being very readily soiled in our sooty, dusty atmosphere; and, however complete a reduction of soot we may hope for through the efforts of some future reform City Council, a town built, as is Sydney, on sandstone and sand is likely always to be dusty.

I take it, then, that we are all agreed (our actions show it) that some kind of woollen clothing is necessary.

What are the lightest suitings in wool? Apparently, flannels, vicunas, serges and tweeds, woven of the finest Australian merino. One should select the lightest obtainable material, insist on having the clothes made easy and forbid all linings, except such as may be essential to hold the material together, and all padding. The armholes should be made much larger than the tailor wishes, even though this allows the coat to rick up at the neck on sitting down; with less comfortable arms one may, of course, obtain a smarter appearance, but in no case can it be more truly said: *Il faut souffrir pour être beau*.

If you desire numerous pockets, so that the endless articles you require to carry—watch, coins, pencil, pen, papers, perhaps thermometer, stethoscope and knife—may be each in its own place, ready to hand, the mere pocket linings become considerable, and should be dispensed with by substituting patch pockets.

Of course, when you try on the suit, you will find much padding, even concealed epaulettes of wadding, but, if you insist firmly enough, it can be removed. This requires some fortitude, as the supreme consideration for the tailor is the appearance of the suit, and, when he relents, as relent he must if you are sufficiently insistent, he may beg you not to mention his name to your friends, lest you ruin his reputation: "You know, doctor," he will say, "you are no credit to your tailor."

Those who are particularly susceptible to cold may prefer to have the waistcoat and even the coat button high for protection on cold evenings, but they should be scrupulously careful to have them quite free. We know well how much less susceptible to pneumonia is the Jack Tar in his open jumper than the soldier in his tightly-fitting tunic.

It is a matter for regret that the wide, open-throated military costume, adopted half-a-dozen years ago for our cadets, is being gradually replaced

¹ Read at a meeting of the New South Wales Branch of the British Medical Association on August 27, 1915.

by the tight tunic, which ignoramuses prefer for its smart appearance.

Lightness is important in itself; a heavy suit is a burden in summer; but lightness is still more important for the permeability it implies. You require free ventilation of the skin, therefore clothes should fit loosely, so as to allow air up the sleeves and legs, and they should be permeable, so as to let heat and perspiration out through them; further, the underclothes should be absorbent, so as to take up and pass out the moist sweat and assist the canvas-waterbag method of body cooling, by evaporation. For this purpose cotton is very much better than wool; surgeons use absorbent cotton, not wool, as a surgical dressing in cases where there is much discharge.

The shirt should be light and full, and absolutely unstarched. It is not necessary now-a-days, even on the most formal occasions, to wear a starched dress shirt front of plate iron rigidity, and for everyday wear even the shirt collar and cuffs need no starch; light gauntlet cuffs do quite well. The material of the shirt may be crêpe, not heavy Oxford matte nor linen; the so-called golf shirts in Japanese crêpe are beautifully light, easy and durable.

The undershirt may be of India gauze, of silk and wool mixture, of silk, of cellular cotton or of linen mesh. This last is very light and strong, and at the same time affords a surprisingly efficient protection against a cold wind. It may be obtained in cellular form, consisting, like mosquito net, more of holes than of matter.

For a long time I contemplated the advisability of dispensing with an undershirt.

I remember a man who wore the same clothes summer and winter—a light tweed suit and linen dress shirt, with neither undershirt nor underpants—and scorned to wear an overcoat except in the very coldest weather. He died of arterio-sclerosis, to which, I think, exposure to cold from insufficient clothing contributed.

While it appears inadvisable to go to this extreme, yet in the summer one may safely dispense with an undershirt and wear a cellular cotton shirt, which will serve the double purpose. The cellular material has been on the market for twenty years, and may be obtained of different weights, and it is an advantage to have the shirts made to order.

Many will hesitate to wear anything but a starched linen collar. If it be of sufficiently large size and low, a turned-down double collar, however stiffly starched, causes but little discomfort in the hottest summer weather.

I take this opportunity to mention that neckties are readily made by purchasing at a cost of about 6d. or 9d. four feet of military dress braid, 2½ inches wide, self colour, blue, grey, red, green, brown or black; one of these will last for several years, wearing even better than silk, and at the same time being so thin as to slip readily between the folds of the double collar.

The drawers should be wide and short, reaching down not further than two or three inches above the knee. They may be made of the same material

as the undershirt, but the cellular cotton does not wear well, and calico is a suitable substitute.

Patients are commonly advised to wear light woollen underclothing, even in the height of summer. After making tests for several years, I feel confident that this is a mere fetish, and that it is quite safe to adopt the linen mesh undershirt and light crêpe shirt or the cellular cotton shirt, without undershirt, as advised above.

Shoes should be worn in preference to boots. They should be low heeled, broad toed, wide and easy, but reasonably well fitting. Tan coloured leather is perhaps a little cooler than black. With modern boot polishes and varnished soles they may be made almost waterproof.

The socks should be of light cashmere or of wool and cotton mixture; some prefer silk or lisle thread, but these latter allow the feet to become sore on much walking.

The coolest hat that can be worn is a low-brimmed pith helmet, next a high-crowned panama or soft felt, and then in order come a boater straw or tall silk, an ordinary bowler, a low-crowned bowler, and, hottest of all, a closely-fitting cloth cap. Some years ago the results of a series of observations made in different weathers by carrying a thermometer in the crown of various head coverings were published in the *British Medical Journal* by a physician.

I am informed by a confrère, who, before the days of motor-cars, was accustomed to drive in a sulky in a grey top hat, that he found it unexpectedly cool, as well as extremely light.

I know a stern, unbending, elderly man, who, in spite of the tearful pleadings of his wife, wears an ordinary felt hat, without any dent. His wisdom is to be admired, though few married men will dare to imitate his practice.

Panamas and soft felts should have high crowns and wide, saucer brims, which will stay down when turned down.

The linen cricket hats so much worn by children at the seaside should be of similar shape and yet fit sufficiently close to prevent them slipping down, so that the crown comes in contact with the child's head.

A plan that should be encouraged is that of dispensing altogether with a hat after sunset, except in the case of those who do not expect to return home before sunrise.

Probably the lightest and most comfortable braces are those usually called French.

A light and efficient rain cloak, so light that there is little temptation to leave it behind in doubtful weather, is made of rubber-covered cotton; one to fit a 12-stone man weighs less than two pounds.

Pyjamas should be loose and light. They are generally made too tight in the neck. The readiest way of remedying this is to leave the top button undone; a better plan is to transfer it about two inches down, and have a new buttonhole made for it. Flannelette is a suitable material. Thick flannelette pyjamas are very warm for winter wear, and then offer little danger from fire, as they are worn under woollen blankets or possibly even over woollen undergarments; by the summer they will

have become sufficiently thin and at the same time the loose nap will have been so worn away as to render them sufficiently non-flammable.

Those who prefer a still lighter material may wear mercerized cotton.

I have not ventured to say anything of women's clothing. Usually, women wear lighter summer garments than do men; the wide, low-necked blouses, sometimes so foolishly called pneumonia blouses, fulfil most of the requirements of a light, loose, summer chest covering. In my opinion, so far from conducing to pneumonia, they avoid those very qualities which, in men's clothes, are likely to favour pneumonia. Probably the bright colours also, of which women are so fond, afford a valuable protection against the actinic rays of sunlight. In India, vivid-hued clothing is commonly worn by both sexes, and Indian Army Medical Officers have suggested the use of orange scarlet shirts and orange scarlet helmet linings for the same purpose. Indeed, I am informed that orange scarlet cellular shirts are made for wear in the tropics.

A full complement of heavy winter clothing, without hat or overcoat, weighs about 11 or 12 lbs.—coat, 44 ounces; waistcoat, 13 ounces; trousers, 28½ ounces; total, 85½ ounces. Flannel-lined waistcoat, 16 or 17 ounces.

A full complement of light summer clothing, as advised above, weighs about 6½ lbs.

The following are the weights of some of the articles of summer clothing.

Suit: Unlined, 59¼ ozs.; lined, 72½ ozs. Unlined coat, 30 ozs.; waistcoat, 9½ ozs.; trousers, 20 ozs.; total, 59¼ ozs. Lined coat, 39 ozs.; waistcoat, 11½ ozs.; trousers, 22 ozs.; total, 72½ ozs.

Crêpe golf shirt: 8 ozs. (Oxford matte, 12 ozs.).

Cellular cotton undershirt: 5 ozs.

Linen mesh undershirt: 7 ozs.

Linen mesh cellular undershirt: 5½ ozs.

Cellular cotton shirt: 9 ozs. (heavy weight, 11 or 12 ozs.).

Calico drawers: 5 ozs.

Cellular cotton drawers: 5 ozs.

Cashmere socks: 2 to 2½ ozs.

Wool and cotton socks: 1¾ ozs.

Lisle thread socks: 1½ ozs.

Silk socks: 1¾ ozs.

Tan shoes: 26 ozs. to 2 lbs. (boots, over 2 lb.).

Panama hat: 2½ to 3 ozs.

Pith helmet: 2 oz., or less.

Light-weight macintosh: under 2 lbs.

Ordinary-weight macintosh: 3½ to 4 lbs.

The articles weighed were those to fit a 6 foot, 12 stone man. The total weights were found, not by adding the separate weights, but by weighing the articles together. By the method described, the weight of the summer suit was reduced by 13 ozs., i.e., from 72½ to 59¼ ozs., and of the full complement of summer clothing by about 24 ozs., i.e., from 8 lbs. to 6½ lbs.

Reports of Cases.

NOTES ON AN EXCEPTIONALLY SEVERE AND PROLONGED CASE OF ENTERIC, WITH MANY COMPLICATIONS.

By C. Bickerton Blackburn, M.D., Ch.M. (Syd.),
Honorary Assistant Physician, Royal Prince Alfred Hospital,
Sydney, etc.

M.R., 40, was taken ill on June 1, 1914, with the usual symptoms characteristic of the onset of enteric fever, and

eight days later the diagnosis was established by a positive blood culture and Widal reaction.

The symptoms were severe from the start, and by June 11, 1914, she was delirious, and from this date to October 5, 1914, she remained oblivious of her surroundings. After this her mental condition gradually improved, and by November 1, 1914, she had become once more a bright, intelligent woman, and was extremely interested to learn that the war was raging in Europe.

On June 20, 1914, she was apparently in imminent danger of succumbing to intense toxæmia, being deeply unconscious, with a feeble pulse of 120, and scanty urine loaded with albumin, and showing numerous epithelial, granular and hyaline casts.

She was taking nourishment badly, and not reacting to sponging or packs.

Rectal saline injections of 1 pint to 2 pints every 8, 12 or 24 hours, according to their retention, were ordered, and were well retained, and the urine was at once increased, and the general condition and pulse improved.

Salines were continued till July 22, 1914, when they began to be returned, and the bowels had become relaxed. In all, 40 pints were retained.

On June 22, 1914, about a pint of fairly recent blood was passed into the bed. She was given a hypodermic injection of morphine (gr. ⅓) at once, and normal horse serum in 10 c.cm. doses every four hours for three days. There was no return of the hæmorrhage. No saline was given for 24 hours, but the temperature then being 105.4° a pint and a half was administered and retained. Sweating soon followed, and the temperature fell to 100.6°, and did not exceed 102° during the next 24 hours.

On June 25, 1914, she had a rigor, and two more rigors on June 26, 1914, and another on June 27, 1914.

On June 26, 1914, breathing was deficient over the whole left lower lobe, high pitched, and accompanied by abundant fine râles. The respiratory rate had risen to 40.

Frequent hot linseed poultices were applied, and five days later the signs had cleared, and the respiratory rate was 24-30, the most usual rate during the acute stage of the illness.

On June 30, 1914, marked frequency of urine was noticed—passed into the bed—and a catheter specimen showed abundant pus cells and bacilli, proved culturally to be the *bacillus typhosus*. These symptoms were much ameliorated by washing out the bladder with boracic acid lotion.

On August 7, 1914, owing to the impossibility of getting any nourishment taken in the ordinary way, nasal feeding was commenced, and for the next eight weeks all nourishment was given in this way. At first 10oz. of prepared milk was given every four hours, but later the amount given was increased to 1 pint four or five times in the 24 hours, and eggs, broth, and Benger's food added. The nutrition began to improve at once in spite of the continuance of the fever. Orange juice was given daily throughout the illness.

On August 15, 1914, a bed sore appeared on the right buttock, and spread rapidly to the size of about two inches in surface diameter, undermined to the extent of another inch. This did not heal for some weeks, but was kept clean, and gave no serious trouble.

On August 27, 1914, the left leg became swollen, and cedematous, and apparently very tender, and several of the superficial veins were evidently thrombosed. The limb was wrapped in cotton wool, and the condition gradually resolved.

On September 25, 1914, as the urine continued to contain much pus in spite of vaccine and metramine (gr. 20) daily, fresh cultures were made, and both *bacilli coli communis* and *typhosus* obtained. A mixed vaccine was then prepared and persevered with till January 7, 1915, when the urine was sterile, and it has remained so since. The albumin and casts had also disappeared.

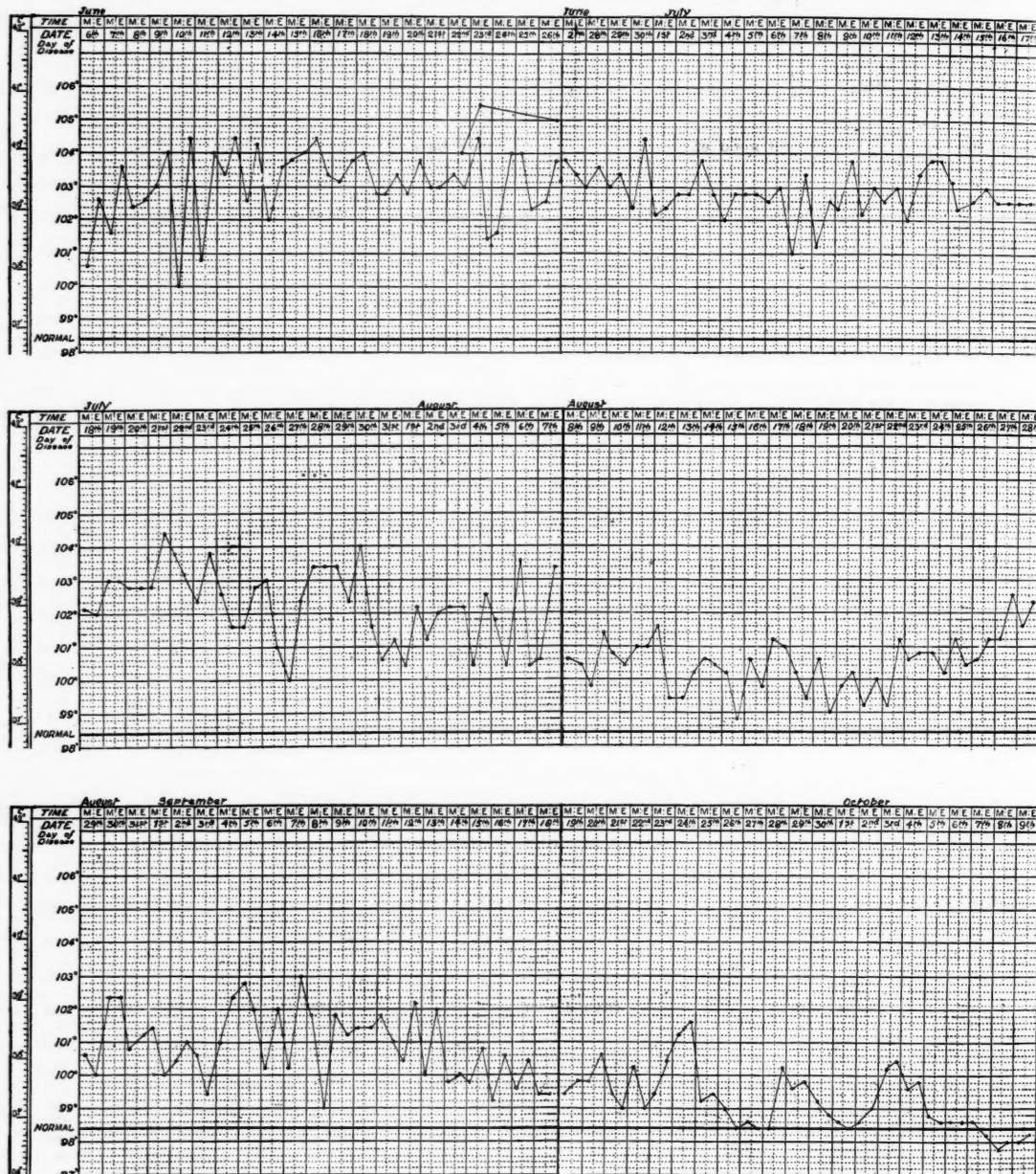
On August 31, 1914, there was a profuse discharge from the right ear, which had long before been infected in an attack of scarlet fever, and had intermittently given trouble since. The left ear had been involved at the same time, and the hearing had been unsatisfactory for years. Though the discharge rapidly lessened under treatment with hydrogen peroxide, the deafness was apparently worse, and when reason returned it was evident that the deafness was ex-

treme. This has, however, gradually improved, and at the present time appears no worse than before her illness.

Throughout the whole febrile period insomnia and violent delirium were marked features, and though many drugs were tried, morphine alone gave any real relief. At first gr. $\frac{1}{12}$ sufficed, and the largest dose given at one time was gr. $\frac{1}{6}$. For many weeks doses of gr. $\frac{1}{10}$ to gr. $\frac{1}{6}$ had to be given very frequently, and always had a soothing

patient seemed collapsed, atropine sulphate (gr. $\frac{1}{150}$ to gr. $\frac{1}{100}$) was given alone. The nurses were permitted to give hypodermic injection strychn. sulph. (gr. $\frac{1}{10}$) at their discretion, and did so on about 30 occasions. They gained the impression that these injections were followed by a speedy improvement on nearly every occasion.

Acetozone solution was given as freely as the patient would take it for the first few weeks, and during the last



and beneficial effect. In fact, she could hardly have been kept in bed without this drug. It was first given on June 22, 1914, and last on October 15, 1914, and during this period was administered 226 times, always hypodermically. Except after the hæmorrhage a small dose of atropine was given at the same time. On some dozen occasions, when the

few months metramine (grs. 15-20 daily) was administered.

Pyramidin, in gr. 4 doses, was tried as a means of reducing the initial temperature, but failed. Later in the illness it acted better, the same dose reducing the temperature 1 to 3°, and increasing the flow of urine.

Bromides, in gr. 20 to 30 doses, had no apparent sedative

effect, except when followed by morphine, and were not continued.

In convalescence, paraldehyde was used a good deal in weaning from the morphine. The usual bitter acid mixture helped to restore the appetite after the temperature had fallen to normal.

Very little trouble was experienced with the bowels. During the greater part of the time they acted spontaneously. Twice there was a little diarrhoea, and on a few occasions a small enema was required.

I had a good deal of hesitation in using a vaccine in the fulminating stage, as I have seen one case in which I believe it did harm. When the temperature kept up unduly long I began cautiously with a 5,000,000 dose, and steadily increased every five days, but do not think it made any difference. Later again I gave large doses up to 500,000,000 for the bacilluria, but only had good effects when I added bacillus coli communis to the typhoid bacilli.

No alcohol was given till the fourth week, when the tongue became very dry, and the state was a typical typhoid one. After this about 3 ozs. of the oldest brandy obtainable was given daily till the temperature settled. After the alcohol was commenced the tongue improved, and the general condition appeared much better both to me and to the two excellent and most observant nurses I had associated with me throughout the whole illness.

A four-hourly chart was kept very carefully throughout the illness, but is too bulky a volume to be reproduced herewith, so I have prepared from it the accompanying daily chart, from which it will be seen that the temperature did not reach the normal until the seventeenth week.

A CASE OF OPTIC ATROPHY FOLLOWING GASTRO-INTESTINAL HÆMORRHAGE.

By J. C. Halliday, M.B., Ch.M. (Syd.), F.R.C.S. (Edin.), D.P.H.

Assistant Honorary Ophthalmic Surgeon, Royal Prince Alfred Hospital, Sydney.

I am indebted to Dr. D. T. Harbison, of Bowral, for the history of the onset in this case. He writes:—

H.C., aged 45, civil servant, arrived at B— from G— on the 12th March, 1913. About a week previously he had had hæmatemesis, and had applied for sick leave, but though leave was granted, he had to await the arrival of a relieving officer. His face was pale, and mucous membranes blanched from loss of blood. He had no pain. He was put to bed and treated for ulcer, probably duodenal. Everything went well for a fortnight, and then he had another severe hæmorrhage, vomiting and passing large quantities of blood by the bowel. Three days later he suddenly lost the sight of the left eye. When I saw him the loss of sight was complete. The pupil was dilated and immobile. A good view of the retina was obtainable by the direct and indirect methods. It was markedly anæmic, and a small hæmorrhage was noted near the disc. The main vessels appeared healthy. A few days later he began to lose the sight of the right eye, but the loss was more gradual, and he could always detect the light of the window when the blind of the darkened room was raised.

The ophthalmoscopic appearance conformed to that of the left eye, except that there was no sign of hæmorrhage. His general health improved steadily, and the vision in the right eye also improved, until, in a few months, he could read $\frac{6}{6}$ and J.I. with an extremely small field of vision.

I saw the patient first in August, 1914, when his fundi presented the usual appearances of optic atrophy. He had no perception of light in the left eye, but could see $\frac{6}{6}$

with his right, and the field was constricted to about 10° around the fixation point. On March 12, 1915, I examined the patient again, and found the condition unaltered.

My interest was focussed upon this case by reading an article by Grout,¹ of New York, on the same condition. This writer draws attention to the rarity of the affection, and estimates that the recorded cases number only 228. A curious feature is the diverse manner in which the visual field is affected. In 20% of the cases there was concentric contraction; in 10% homonymous hemianopsia; in 23% the lower half of the field was lost; and in 13% there was a central scotoma. No one theory can explain all these various defects. Hemianopsia would naturally suggest a blocking of an artery in the optic radiations or about the calcarine fissure. In Grout's case the visual field of the right eye was represented by a superior temporal sector, that of the left eye by the lower half. This was explained by the ophthalmoscopic appearance, which showed blocking of several small retinal arteries. The majority of cases may be explained by the theory that the retinal ischæmia produces a degeneration of the ganglion cells.

In cases that recover or improve, it is likely that the periphery of the retina will suffer most damage, and hence the constricted field. The survival of a small area of retina around the macula, as in the present case, may be due to its nutrition by a cilio-retinal branch. Dr. Harbison suggests that in the early stages one might try the effect of vasodilators.

In 1904 Simeon Snell² published a case following post-partum hæmorrhage, and previously he had seen one after menorrhagia. He mentions that in three of the published cases, traces of retinal hæmorrhage were found. In the present case an opinion was required on a practical point, namely, whether the patient had sufficient sight, and reasonable prospect of its continuance, to resume Government employment in a semi-clerical position. I declined to make any dogmatic statement, but thought that the patient had a fair chance of maintaining his vision.

Reviews.

HÆMATOLOGY.

A book may be judged from three standpoints. The general appearance is of importance, and paper, type, binding and plates are all matters which make or mar it. In the next place, a book is rendered more attractive by a suitable title, and although Shakespeare throws doubt on the significance of a name, in the case of a book, the name plays a distinct and often a determining rôle. Lastly, there is the subject matter. In the case of Dr. Gordon Ward's publication,³ the general appearance, binding, paper, type and illustrations are all alike extremely good and, from the publisher's point of view, the work may be regarded as first class. The title is attractive, but misleading. Dr. Ward has not dealt with bedside hæmatology at all. He has given a detailed account of the clinical aspects of those diseases which are spoken of as blood diseases, and in which pathological changes are met in the blood and the blood-forming organs. These accounts include hæmatology, but not as the salient study. Bedside hæmatology suggests the study of blood changes carried out at the bedside. We are therefore driven to the conclusion that the title has been selected without judgement and the work suffers from a misnomer.

In regard to the contents of the volume, it is possible to analyse the matter in various ways and from a number of aspects. An exhaustive and critical review would occupy a great deal of space, and would involve a debate on nearly every chapter of the volume. A cursory review must remain unsatisfactory. We are therefore constrained to select a few points for brief discussion, and to leave it to each individual reader to judge for himself as to the exact value of the views expressed. If this entails a recommendation to purchase the volume, the author has no more than his deserts, for the presentation of his views and the formulation of the doctrines for which he pleads are alike excellent and worthy of wide recognition.

¹ Grout, *Arch. of Oph.*, Vol. XLIII., No. 3.

² Snell, *Trans. Oph. Soc. of the U.K.*, Vol. XXIV.

³ *Bedside Hæmatology: An Introduction to the Clinical Study of the So-called Blood Diseases and of Allied Disorders*, by Gordon R. Ward, M.D. (Lond.), 1914. Philadelphia and London: W. B. Saunders Company; Svo., pp. 394, illustrated. Price, 15s.

To begin with, he tucks away at the end of his introduction the most important page of printed matter in the whole volume. This is the classification of affections of the blood and blood-forming organs. He selects a primary classification, with which we are in full agreement. Affections of the blood-forming tissues, subdivided into general and localized, affections of red-cell formation and those of the circulating red cells, affections of white-cell formation and those of the circulating white-cells, affections of the plasma and lastly unclassified affections form his headings. Each class is subdivided into primary and secondary. It is in the extended classification that we find inferences and assumptions which are not universally accepted, and to which we are disposed to take exception. For example, Addisonian anaemia or pernicious anaemia is entered as a secondary affection of the increased destruction of the red-cells. In the description of this condition, he defines this condition as a specific infection, with an organism not yet isolated. The organism or its products are powerfully hæmolytic, and the usual site of invasion is the alimentary tract. It is highly probable that pernicious anaemia is due to a micro-organism or several forms of micro-organisms, but recent researches into the histopathology of this condition have revealed one highly important fact which renders Dr. Ward's definition unacceptable. In the spleen of persons dead of this disease, it is found that the venous radicals leading from the large blood spaces are more or less blocked by inflammatory exudations and round-cell infiltration. The blood circulating through the splenic vessels is obstructed in the lacunae and the normal process of disintegration of red-cells in this situation is largely increased. It is a common occurrence in this disease that the amount of hæmolysis, as indicated by the high colour index, varies from day to day. This variation is regarded as the result of the variations in the permeability of the venous channels leading from the blood lakes. According to this observation, the hæmolysis would not be due to a special attribute of the bacterium, but to the effect of the primary splenic inflammation, causing stasis and consequent destruction of the red blood corpuscles within the spleen. Moreover, the bacteriological evidence so far tends to suggest that the causal micro-organism of pernicious anaemia is not a hæmolytic bacterium. In the next place, it appears to us to be unwise to dogmatize within the limits of a definition in the way the author has done. The reader is apt to question the details included under subsequent headings, on the simple ground that the definition is so concise and yet so improbable.

Dr. Ward does not indulge in dogmatism throughout the volume. In the chapter dealing with the leukæmias, he is unnecessarily cautious, both in his definitions and in his descriptions of the pathology. We miss a great deal in the true hæmatology of these leukæmias. Ehrlich's teaching was that the blood picture is diagnostic and that the characteristics of myeloid leukæmia are: (i.) mononuclear myelocytes, (ii.) an increase of neutrophile, eosinophile and mast-cell granules, (iii.) the occurrence of atypical forms of leucocytes, e.g., dwarf forms, and (iv.) the presence of large numbers of nucleated red blood corpuscles. These points are not emphasized by Dr. Ward, and some concentrated searching is necessary to find the mention of these essentials. In the descriptions of the clinical signs and symptoms, a want of clearness results in an indefinite impression of the usual clinical picture of the disease. The illustration of skin nodules, for example, increases the confusion and tends to the conception that comparatively uncommon manifestations are characteristic. Notwithstanding these defects, the descriptions of the leukæmias include practically all that is known, and if the chapters are read with great care, a vast amount of very valuable knowledge can be gleaned from them.

The description of carbon-monoxide poisoning is less well written, and we miss in this connexion all reference to the methæmoglobinæmia of antimoniretreated hydrogen poisoning. On the other hand, the description of chlorosis appears to us to be very excellent and to stamp the author as an undoubted authority on a difficult subject. Indeed, it may be said that, in the majority of books on blood diseases, the one subject which is treated least well is usually chlorosis.

The last chapter contains a summary of the chief blood changes of a large number of diseases. Some of this is useful, some is informative, and some might well have been omitted.

In conclusion, one word must be devoted to the very fine illustrations. We have already recorded our appreciation of the block-maker's work. The pictures have been selected with care and good judgement, and a most estimable method has been adopted of supplementing microphotographs by drawings, in which the principle characters have been accentuated. These pictures add very considerably to the value of the book. Dr. Ward is to be congratulated on his work. It is not unreasonable to prophesy for this volume a long life, several editions and a wide-spread popularity.

MATERIA MEDICA.

With the constant additions made to medical knowledge, it is difficult for authors of students' text-books to steer between the scylla of too great condensation and the charybdis of allowing a book to attain unwieldy proportions. Reginald Bennett, the author of *Materia Medica*,² has chosen to give the latter alternative a wide berth. This work appears to be more suited to students for pharmacy. Since the therapeutical references are of the briefest, and the pharmacological actions of drugs can only be inferred from the classification and from occasional brief references, we do not feel justified in recommending the book to students of medicine.

The drugs are classified according to their general pharmacological action, and this is frequently misleading. The grouping together of belladonna, stramonium, hyoscyne and cannabis indica under the heading of delirifacients is certainly open to objection, and gives an erroneous idea of the medicinal value of these substances. The grouping of morphine, codeine, apomorphine and diamorphine as somnifacients is open to still greater objection. A useful item of the book is the dose tables, arranged alphabetically, and giving the metric and imperial measures. The appendix, dealing with the general principles of incompatibility, will be found instructive. Those who need a Latin dictionary and have not one at hand will find the short selection of Latin words and phrases to be used in the directions in prescriptions useful. It is scarcely necessary to state that the edition under review is based on the 1914 Edition of the British Pharmacopœia.

A scheme for the organization and development for scientific and industrial research was issued on July 26, 1915, by Mr. Arthur Henderson, of the English Board of Education. According to this scheme, a Committee of the Privy Council should be set up for the purpose of advising Parliament in regard to the expenditure of money for scientific and industrial research. A small Advisory Council should be appointed to act as an executive body to the Committee. This Council, it is suggested, should be composed of men eminent in the scientific world and those engaged in industries dependent on scientific research. This scheme is intended to be a permanent organization, and with the possible exception of the Medical Research Committee in connexion with the National Insurance Commission, it is the first admission on the part of the British Government of an important economic aspect of science.

According to a report in the *Times* newspaper, the members of the Committee of the Privy Council will be The Lord President, The Chancellor of the Exchequer, The Secretary for Scotland, The Chief Secretary for Ireland, The President of the Board of Education, and the President of the Board of Trade, together with the Right Honourable Viscount Haldane, the Right Honourable Arthur H. D. Acland and the Right Honourable Joseph A. Pease.

The first members of the Advisory Council will be The Right Honourable Lord Rayleigh, Mr. G. T. Beilby, Mr. W. Duddell, Professor B. Hopkinson, Professor J. A. McClelland, Professor R. Meldola, Mr. Threlfall, and Sir William S. MacCormack.

² *Materia Medica and Pharmacy for Medical Students*, with an Appendix on Incompatibility, by Reginald R. Bennett, B.Sc. (Lond.), F.I.C.; Third Edition, 1915. London: H. K. Lewis; demi 8vo., pp. 248.

The Medical Journal of Australia.

SATURDAY, SEPTEMBER 11, 1915.

Cancer of the Rectum.

When academic knowledge conflicts with the results of experience, we may assume that the deductions made from observed facts are incorrect. Not infrequently errors in theory arise from a too wide generalization of a principle which is true when applied to the original subject. In connexion with malignant disease, it must be remembered that the pathology and aetiology are yet obscure, and that when rules are set up for the purpose of guiding our practice, the basis is empirical, and consequently the rule may not have universal application. Surgeons have dealt with carcinoma of the breast for many years by free removal of the tumour and of the contiguous, apparently healthy tissue and by removal of the lymphatic drainage area, because experience had taught them that extension always follows the lymphatic vessels, and that within a limited time, metastatic growths appear in the regional lymphatic glands and in distant organs. The truth of these observations cannot be challenged, but until the nature of the disease is understood, the removal of tumour, contiguous tissue and the lymphatic area must be regarded as an empirical, mutilating and not very satisfactory method of coping with the condition, albeit the best.

At a meeting of the New South Wales Branch of the British Medical Association, Dr. Thring recently introduced a discussion, a summary of which is published in this issue. The divergence of opinion is an indication of the slender scientific basis of the therapeutic structure. Dr. Thring referred in his article to the work of Ernest Miles. This work has been carried out with the greatest care and skill, and the findings are accurate and important. The extent of the lymphatic drainage, as mapped out by pathological conditions, has been made known, and if we were to follow the doctrine accepted in regard to mammary malignant disease, there could be no doubt as to the wisdom of the removal of all structures within this area in every case of rectal cancer. Indeed, Dr. Thring repeatedly referred to the ex-

tensive, radical operation as an ideal one, which he would have wished to have performed, had the condition of the patient permitted it.

In order to arrive at a sound conclusion in this connexion, it may be well to examine the grounds for the adoption of the doctrine of the so-called complete operation. Surgeons of experience have noted that the lymphatic glands are involved in cases of rectal cancer relatively late in the course of the disease. Indeed, the direct extension of the growth appears to form a more serious menace to the life of the patient than the spread to the regional lymphatic glands. More than that, it is by no means uncommon for metastatic growths to appear in the liver at a time when the lymphatics in the pelvis are still free from involvement. A careful examination of the glands may reveal a septic infection, without any trace of new growth. It would therefore be reasonable to suppose that extensive removal of pelvic tissue may not enhance the chances of freedom from recurrence. Miles himself has not been able to tell a pleasant story in this respect. He came to the conclusion that a very extensive operation was unable to prevent recurrence. In 93% of the patients who survived the immediate effects of the operation, recurrence was noted within a period varying from six months to three years. In addition, it must be remembered that the immediate mortality of the operation is considerable.

In opposition to the views taught by Miles, Harrison Cripps has practised a limited resection of the growth, on the ground that, in the majority of operable cases, glandular involvement has not taken place at the time of the interference. These operations apparently yield comparatively good results, although the immediate mortality is not small.

With a disease like cancer, it is difficult, if not impossible, to determine the exact relative value of a given treatment. The treatment of rectal cancer may be the complete operation performed by the abdomino-perineal method, the perineal or sacral methods, or inguinal colostomy. The additional risk of the first-named as compared with the second group of operations may out-balance the possible advantages due to a heightened prospect of freedom from recurrence. The relative mortality of the three classes of operation may be expressed in the

following terms: The abdomino-perineal operation has the highest mortality. Kraske's operation and its modifications come next, the perineal operations have a lower, but still considerable immediate mortality, while colostomy is relatively free from serious risk.

What do we know of the end results of these operations? Unfortunately, statistics do not exist from which accurate information can be culled. In the absence of figures, it may be assumed that the abdomino-perineal operation gives the patient the best chance, if he survive the shock of the operation. It has some distinct advantages. In the first place, it is possible at the time of its performance to observe the lymphatic glands and to determine whether they are involved in the malignant process. In the second place, when the abdomen is opened, the surgeon can examine the liver, and if metastasis has occurred, the patient may be spared a useless operation. In the last place, it is much easier when operating in this manner to ascertain whether the mesentery is extensive enough to admit of its being brought down to the anus or not. On the other hand, the perineal operation usually proves sufficient when the growth is not very extensive. It is a significant fact that in 86% of these cases, the growth is within six inches of the anus, and in all these cases, provided that the liver is free from secondary tumour formation and that the lymphatic glands are not involved, the perineal method enables the surgeon to give the patient a reasonable chance of cure.

The third method does not appear to be very sound. To leave the tumour in its place and to open the intestine in the iliac region is opposed to the fact that a malignant growth should be removed as early as possible in every case. But experience teaches that many rectal growths tend to become still more chronic after colostomy and that the length of life after this operation may, on an average, be nearly as long as the length of life after removal. The patient is certainly more comfortable with an artificial anus in the inguinal region than with one in the perineal region. He can attend to the former himself, while this is much more difficult in the latter case.

It thus appears that as long as the cancer is not subjected to treatment at a very early stage, which,

in the nature of the conditions, is rare, it is doubtful whether the complete operation should be regarded as more ideal than the more limited resection, and the surgeon will have to determine from case to case which of the three procedures is most likely to give the patient the longest freedom from recurrence, the greatest chance of complete cure and the soundest guarantee of comparative comfort.

THE FEDERAL MEDICAL COMMITTEE.

The invitation of the Federal Parliamentary War Committee, after having received the approval of the Department for Defence, has gone out to the six Branches of the British Medical Association in Australia. The Presidents of the Branches have accepted the office of member of the Federal Medical Committee, and several have already appointed proxies. We understand that the first meeting of the Committee will be held in Melbourne, on September 10, 1915. The formation of the State Medical Committees is also proceeding. From the scheme formulated by the Federal Parliamentary War Committee (see *The Medical Journal of Australia*, September 4, 1915, p. 235), we gather that the treatment of returned invalid soldiers will be placed in the hands of the British Medical Association, through the agency of the State Medical Committees, or the Presidents of the Branches, and that Department for Defence does not propose to impose any conditions on the men undertaking the treatment which might be regarded as irksome or unduly officious. In this there is cause for satisfaction. It must be remembered that the Federal Medical Committee is an *ad hoc* organization, instituted for the special purpose of the war. The Military Authority has done wisely in selecting the Branch Presidents as members of this Committee, firstly, because a personal selection is avoided, and, secondly, because it was thought that a Committee consisting of one man for each State would be less cumbersome than a Committee constituted like the Federal Committee of the British Medical Association. The members of the British Medical Association have declared, through the mouthpieces of the six Branches, that they are prepared to carry out this treatment. We have already dealt at some length with the terms of service and with the de-

sirability of retaining a certain degree of freedom from departmental control. Dr. A. Honman, the President of the Victorian Branch, obtained some concessions from the Minister for Defence in regard to the analogous matter of civilian medical service at the camps during the present epidemic of cerebro-spinal meningitis. Medical officers called upon to render service will take precedence of the military officers, and civilian practitioners undertaking three weeks' service in camp will be exempted from further service. Furthermore, the medical practitioners on the Reserve will not be mobilized. These promises are further indications of the desire on the part of the Minister for Defence to treat the medical profession well.

There is only one point in regard to the understanding between the Department and the British Medical Association to which exception might be taken. On August 7 we called attention to the fact that the small honorarium offered to the medical men in the country districts might or might not be paid out of consolidated revenue. The Federal Parliamentary War Committee has now openly announced that the cost of this work would be a suitable charge on the patriotic funds, by which we understand that the money collected from the public on Australia Day will be utilized, among other things, to remunerate medical practitioners for this work. It may be urged that it is merely a sentimental difference whether the remuneration is derived from funds subscribed under compulsion in the form of taxes by the people of the country, or whether it forms part of voluntary gifts from the same people to the sick and wounded soldiers. It may be a sentimental difference, but the majority of men have regard to sentiment, and it is difficult to overcome a prejudice. On the other hand, the State has undertaken the duty of providing the soldiers with treatment, and the obligation of providing the means to cover the cost of this treatment should not be shifted on to the shoulders of private citizens. The subscribers to the Australia Day Fund did not contribute for the purpose of paying doctors, and we venture to doubt whether doctors would be willing to accept payment from this source. These reasons suffice to support the Victorian and New South Wales Branches of the British Medical Asso-

ciation in their refusal of remuneration for the services rendered. The funds may be used for the provision of drugs, dressings and similar necessities, but not for doctors' fees.

THE FIRST AUSTRALIAN GENERAL HOSPITAL.

The deplorable incidents which have led to the recommendations of the Army Council to the Commonwealth Government that Lieutenant-Colonel Ramsay Smith and Matron Inspector Bell be recalled to Australia and that Lieutenant-Colonel J. W. Barrett be relieved of his military position are not divulged in the official papers which were laid upon the table of the Federal Library last week. These documents deal exclusively with the subsequent course of events, and more especially with the attitude adopted by the Department for Defence. It appears that after the Army Council had instituted the enquiry with the concurrence of the High Commissioner for Australia, the Minister for Defence suggested to Lady Helen Munro Ferguson that the Commissioner of the Red Cross Society in Egypt might make some personal and discreet enquiries into the matter. In regard to the position of Lieutenant-Colonel Ramsay Smith and Matron Bell, no further difficulty has arisen, and it is understood that both the former and Lieutenant-Colonel Barrett will be placed on the retired list of the Commonwealth Military Forces on their arrival in Australia. In regard to the latter officer, a suggestion was made by the Officer in Command of the A.I.B. Depot in Cairo that he should be allowed to remain in Egypt in order that he might advise the Director of Medical Forces in his private capacity. It was felt that this possibility would perpetuate the friction which had existed in Egypt, and the suggestion that he be allowed to remain on the private staff of the Director was consequently rejected. The Red Cross Society was thereupon informed of the action of the Army Council and of the Commonwealth Government, and was told that no objection would be raised if the Society desired to retain Dr. Barrett's services in Egypt. It was made quite clear that he had been removed from military service, either with the Australian or the Imperial Forces, and that any duties he might take up must be confined to the work of the Red Cross Society. A further suggestion was made by the Secretary of State for the Colonies that Dr. Barrett be retained as ophthalmic surgeon, in addition to the position he might fill in the Red Cross Society. The Minister for Defence, however, has adhered to his decision, pending the arrival of all the papers in connexion with the case.

It appears that Dr. Barrett has made an application to the Minister that he be supplied with a statement of the charges made against him, and, further, that a court of enquiry be convened in Egypt to investigate the charges. On July 31 the Minister made the statement in the Senate that, in time of war, officers of the Australian Military Forces could not demand a court-martial or a court of enquiry,

and that they held their offices during the pleasure of the Government. This statement was made in connexion with Lieutenant-Colonel Ramsay Smith's case. It must be assumed that the Army Council would not recommend the removal of two officers from the military forces without irrefutable evidence of neglect of duty, or other irregularities. The nature of the charges will, no doubt, be disclosed at a later date, since the Commissioner of the Red Cross has stated that there were allegations of want of organization in the hospital, delay and lack of attention to the wounded *en route* to the hospital, shortage of medical officers, and neglectful and unauthorized use of the X-ray motor-car. In a message despatched by the Minister to the Secretary of State for the Colonies on July 13, the following passage is suggestive: "It is suggested that trouble is due to the treatment of officers and nurses by the officer commanding and by the registrar." These incidents are regrettable in the extreme, but there appears to be no doubt as to the wisdom of the course adopted, since the proper treatment of our wounded must be a sacred charge of the medical practitioners in authority at the front.

—o—

THE ABBASIAN DETENTION BARRACKS ISOLATION HOSPITAL.

The Abbasian Barracks, at Cairo, has been transformed into an isolation hospital for soldiers suffering from venereal disease. The Director of Medical Services called upon Lieutenant-Colonel J. B. Nash to take charge of this hospital. Although he felt that this duty was not one for which he was specially suited, he obeyed without murmur, merely pointing out that "It is not my job, sir; but if you desire it, my best efforts will be put forth to run the show." The hospital had existed for this purpose for about eight weeks. There were 492 patients in the institution. The majority of the patients are placed on verandahs, while extra accommodation is found in tents pitched on the sands. Of the eight wards, one is reserved for men who are acutely ill. This ward contains beds, while all the others have but mattresses on the floor.

Of the 492 men, 190 were among the brave Australian boys who performed deeds of unexampled bravery at Anzac Cove on April 25, 1915, when effecting a landing on the Gallipoli Peninsula. Colonel Nash expresses his whole-hearted admiration for these men, in spite of the fact that they were at the time detained under his care for the results of their folly.

We are informed that syphilis is comparatively uncommon. Of 108 Wassermann tests in cases of sores on the genitals, 29 proved positive, and six doubtful, while the remainder were undoubtedly negative. These bacteriological findings coincided with the clinical appearances of the sores.

In regard to the infections, a somewhat astonishing account is given. The vast majority of the patients have been infected on the journey to Suez. One transport which did not call at any port between Perth and Suez contained 25 venereal pa-

tients. The patients in the hospital include British, Australian and New Zealand soldiers. The number of Egyptian infections appears to be relatively small. The Cairo prostitutes are natives of the various countries bordering on the Mediterranean to the north. These women differ from the prostitutes in British countries, in that but few of them had borne children. It is stated that they exercise considerable care to keep themselves free from venereal infection.

Alcohol is not obtainable readily near the hospital, and this fact is of importance in the treatment of the men, since the majority do not exhibit any power of resisting the temptations of taking strong drink. The treatment consists in giving some form of sandalwood oil internally and in carrying out the usual urethral injections for gonorrhoea. For syphilis, salvarsan, injected intravenously, and grey oil for intramuscular injection are given. The immediate effects appear to be satisfactory. The men submit to treatment readily, in spite of the fact that a general reaction lasting for about 12 hours is usual. The aim of the treatment is to get the men well as rapidly as possible, in order that they may return to the fighting line. When a cure cannot be achieved within a reasonable time the men are sent home.

In curious contrast to this account is the experience of the first batch of the returned invalided men from Egypt. A number were returned on account of an alleged syphilitic infection. (It must be noted that this was before Colonel Nash had charge of the hospital.) Only three of these men were found to be infected. In some cases, the history was sufficient to correct the diagnosis, while in others the clinical aspects of the cases were reasonably like those of lues. The Wassermann reaction was utilized to confirm the clinical diagnosis in every case.

—o—

THE TOBACCO FUND.

Contributions to our branch of the Over-Seas' Club Tobacco Fund have been very few during the past few weeks. We venture to appeal again to members to contribute a shilling or two for the comfort which our Australian boys at the front may derive from a smoke.

	£	s.	d.
Amount previously received	4	12	0
Drs. J. and A. J. Mackenzie, New South Wales..	1	1	6
Dr. E. Brooks, Tasmania	0	5	0
Total	£5	18	6

THE SCHLINK FUND.

Dr. Cecil Purser's Fund for the purpose of assisting Captain Schlink to meet the heavy legal expenses to which he has been put in connexion with the attack made upon his honour in the Senate does not appear to have attracted much attention (see *The Medical Journal of Australia*, September 4, 1915, p. 228).

	£	s.	d.
Dr. Cecil Purser	3	3	0
" F. P. Sandes	3	3	0
" Hilton C. Smith	1	1	0
Sir Thomas Anderson Stuart	3	3	0
Total	£10	10	0

The Lunacy Department in Victoria is seeking, at the present moment, a temporary medical officer of either sex, and, in common with numerous other institutions, is experiencing some difficulty in obtaining applications. The opportunity is an excellent one for practitioners to obtain a good insight into the administrative work of a hospital for the insane, and to obtain experience in the important special branch of medicine, namely, psychiatry. We can recommend members to apply for this position, or at all events, to make enquiries, in regard to the duties, of Dr. W. Ernest Jones, Inspector-General of the Insane, Old Treasury Buildings, Spring Street, Melbourne.

THE MELBOURNE JEWISH AID SOCIETY.

The annual report of the Melbourne Jewish Aid Society was presented to the Life Governors and members on June 29, 1915. During the 27 years of its existence the society has extended monetary benefit to an increasing number of persons in financial difficulties. During the year 150 applications were received, and grants were made to 141 persons. The amount lent was £3,117. Since the inauguration of the society £31,690 has been granted in this manner. The borrowers included tailors, fruiterers, drapers, cabinetmakers, dealers, bootmakers, watchmakers, hawkers, etc. The value of the work of assistance of this society is very great, and the help tendered has been the means of saving a large number of persons from social ruin. The President records with great regret the loss of three highly esteemed workers. Mr. Joseph Kronheimer, Mr. Isaac Jacobs, and Mr. Bernard Marks, who died during the course of the year, have been ardent supporters of the society in the past.

QUEEN'S MEMORIAL INFECTIOUS DISEASES HOSPITAL, FAIRFIELD.

In order to bring the financial year of the Queen's Memorial Infectious Diseases Hospital, Fairfield, into line with the Governmental year, the Medical Superintendent has issued his report for a period covering nine months, and ending on June 30, 1915. The fortunes of this institution appear to be still in the balance, but the members of the present board are working energetically to a satisfactory solution of the various difficulties, and the prospects of increased utility for the future appear to be bright.

During the nine months under review 1521 patients were admitted into the hospital, and 135 remained in the hospital on October 1, 1914. At the end of the period 177 patients were still under treatment. Of the 1,489 patients whose treatment was concluded 69 died, which is equivalent to a case mortality of 4.63; and 1,410 were discharged. The daily average of residence of the patients was 144.2. The minimum number of patients was 101, and maximum 212. The Medical Superintendent expresses the opinion that the daily average should not be accepted as a representative figure for the year, since the quarter missed is invariably a busy one.

The number of patients treated for diphtheria was 1,251. In 63 cases the disease was fatal, whereas in 11 death occurred within 24 hours of admission. The actual number of patients in whom the treatment was completed was 1,203, and the case mortality would therefore work out at 5.28%, and not 5.15%, as stated in the report. Again, if the deaths occurring within 24 hours of admission be eliminated, the number of patients on which to calculate the percentage would be reduced to 1,181, and the case mortality to 4.31%. The differences are not great, but for statistical purposes it is essential, in our opinion, to make a calculation of case mortalities from the actual number of patients whose treatment has been completed within the period under review.

The Medical Superintendent records that diphtheria has become a much more serious disease in Melbourne during the last six years. The laryngeal complications are less frequent, which he attributes to the practice of sending patients to the hospital at an earlier stage of the disease. On the other hand, the number of malignant cases appears to be considerably greater. In regard to the age incidence of the disease, it appears that of the 1,243 persons admitted

for diphtheria 39.66% were between 5 and 10 years of age, 20.03% were under 5 years of age, 19.46% were between 10 and 15 years, 14.23% were between 15 and 25, 4.98% were between 25 and 35, 1.12% were between 35 and 45, and 0.32% were between 45 and 55. There was one patient over 65 years of age. The number of females affected was 713, and of males 530. The mortality works out at 9.2% in children under 5 years of age, at 5.3% in children between 5 and 10, at 4.9% in those between 10 and 15, and in 1.1% in young persons between 15 and 25. It will thus be seen that the fatality of the disease decreases markedly with increasing age, and that diphtheria after the second decade is not a dangerous affection. The relation between the number of days elapsing before treatment is instituted, and the mortality is very well illustrated. The following table shows this:—

Number of Days Before Admission.	Number of Patients.	Deaths.	Mortality. Per Cent.
1 ..	368 ..	3 ..	.8
2 ..	382 ..	12 ..	3.1
3 ..	222 ..	20 ..	9.0
4 ..	127 ..	11 ..	8.7
5 ..	55 ..	5 ..	9.1
6 ..	27 ..	3 ..	11.1
7 ..	21 ..	3 ..	14.3
Over 7 ..	25 ..	6 ..	24.0
Non-specified.	16 ..	— ..	—
Total ..	1,243 ..	63 ..	5.07

In another table the Medical Superintendent illustrates the relative danger of faucial, nasal, laryngeal and conjunctival diphtheria. The number of cases of nasal laryngeal and conjunctival infections is small, and it is therefore doubtful whether the mortality rate should be accepted. There were 927 cases of pure faucial diphtheria, with two deaths. The average amount of diphtheria antitoxin was 7,224 units. In 34 cases the nasal cavity alone was affected. One of the patients died. There were 16 cases of pure laryngeal diphtheria, with 3 deaths, 36 of faucial and laryngeal diphtheria with 4 deaths, and 16 of faucial, nasal and laryngeal diphtheria with 3 deaths. It thus appears that the larynx was involved 68 times, and that the mortality of these cases was 14.7%. The amount of antitoxin given in these cases was large. The average being over 22,000 units. In the last place 212 cases of faucial diphtheria were complicated by a spread of the infection on to the nasal mucosa. The mortality among these patients was very high, working out at 23.6%. The average amount of antitoxin injected was 34,415 units. It is obvious that the cases in which the amount of mucous membrane involved was great were those in which the disease had existed for a considerable time before the treatment was applied. In the endeavour to cope with these successfully, very large doses of antitoxin were required. As is shown in the table above, the treatment is incapable of saving a large proportion of children with neglected infections. The Medical Superintendent is therefore wise in pleading for an early injection of a medium size dose of antitoxin. He points out that this practice saves both life and money.

The number of patients admitted for the treatment of scarlatina was 120; and there were 15 patients in hospital at the beginning of the period. Two patients died, which is equivalent to a case mortality of 1.78%. In both cases the disease was complicated at the time of admission once with diphtheria and once with diphtheria and measles. The ages of the patients admitted are given in a special table. It appears that 42.5% were between 5 and 10 years of age, 22.5% were between 10 and 15 years of age, 16.6% were between 15 and 25 years, and 13.3% were under 5. The usual complications of adenitis, otitis, and albuminuria were observed. In 40 cases diphtheria was present, and in 34 of these cases the two diseases co-existed at the time of admission.

The number of cases of measles dealt with was 94. Of these 83 were admitted during the nine months, and in 93 cases the treatment was completed. Only three of the patients were under 5 years of age, and the remaining 80 were over 15. It is therefore not surprising that no deaths occurred.

Abstracts from Current Medical Literature.

THERAPEUTICS.

(99) The Use of Hormones.

G. R. Murray discusses the employment of hormones in medicine (*Practitioner*, February, 1915). He divides them into two groups, the acute and the chronic, according to their immediate or remote action. He considers the uses of these two classes of hormones separately. The hormones of the acute class are available to produce rapid and immediate results. The most important member of this group is adrenalin. Locally applied, it serves as a powerful vaso-constrictor. It may be used for arresting hæmorrhage from superficial cuts and abrasions and in epistaxis. It may be used in hæmatemesis and, as a suppository, for bleeding piles. It has also been used in the treatment of shock, when it is administered by hypodermic injection. Its use is contra-indicated in patients with abnormally high blood pressures, in cases with hæmoptysis and in any case in which glycosuria is present. The hormone of the pituitary gland, hypophysin, has been used in the treatment of shock. Owing to its action on the muscular walls of the intestines, it is useful in tympanites and post-operative distension. It has a pronounced action on the uterus. It has a marked diuretic action, and has been employed in uræmia. It increases the flow of milk from the lactating mammary gland. It has been found to be useful in the treatment of the persistent vomiting, which occurs in the crises of Graves' disease. The most important of the chronic hormones is that present in thyroid extracts. These hormones are readily obtained, and are absorbed from the alimentary canal without losing their physiological properties. In addition to their more frequent employment in cases of myxœdema and cretinism, these extracts can be employed for the treatment of the simple parenchymatous goitre of puberty. They are also useful in cases of psoriasis and other chronic lesions of the skin.

W. B. Bell discusses the uses of hormones in gynæcological and obstetrical disorders (*Practitioner*, February, 1915). He considers that the internal secretions regulate not only the formation of the genitalia but also their subsequent and complete development. He thinks that hormones should be used for derangements of puberty, for derangements during the reproductive period, and for disorders of the menopause. In the first period he employs hormones from the pituitary, thyroid and ovarian tissues. During the reproductive period he recognizes conditions of hypothyroidism and hypopituitarism, and uses extracts of the thyroid and pituitary glands freely. At the menopause he considers that the symptoms amenable to hormone therapy are: circulatory, as hot flushes and cold sweats; general meta-

bolic, as obesity, mental apathy and lassitude; those arising from disorders of the endocrine organs, such as myxœdema and exophthalmic goitre; and psychical, as mental depression. In obstetrical practice, he employs hormones for sterility, in cases of habitual abortion, in osteomalacia and in eclampsia. He lays great stress on the use of pituitary extracts in parturition. He is of opinion that the accoucheur must be quite certain that labour cannot be obstructed before administering the hormone.

H. E. Waller discusses the employment of hormones in the diseases of children (*Practitioner*, February, 1915). He points out that certain hormones are powerful pharmacological agents, so that they exercise a marked influence after administration, which is often of great value, even in cases in which the organ from which the hormone is derived is not at fault. He employs thyroid extracts for a long series of disorders, e.g., nocturnal and diurnal enuresis, urticaria, cretinism, epistaxis, menorrhagia, purpura, dental caries, epilepsy, tetany, etc. He considers that the wide range of usefulness of thyroid medication is in part due to the fact that the thyroid stimulates the suprarenals.

(100) The Prevention of Cerebral Syphilis.

J. Collins is of opinion that the cerebral forms of syphilis are not susceptible to curative measures, wherefore he demands greater attention to their prevention (*Journ. of the Amer. Med. Assoc.*, July 10, 1915). He thinks that there are only two substances, arsenic and mercury, that kill the pale spirochaetes. Their administration encompasses the cure of syphilis. He is of opinion that the minds of physicians should be purged from the belief that in potassium iodide they possess an anti-syphilitic agent. The adequate treatment of syphilis consists in the proper use of salvarsan and mercury, begun at the earliest possible moment after infection, and kept up until all biochemical evidence of the disease has ceased, while the metabolism of the patient is maintained as normal as possible. He believes that, in some persons, the spirochaetes invade the nervous tissues in the early stages of infection, so that he advocates treatment of a vigorous nature as soon as possible, and holds that it is harmful to wait for the so-called secondary manifestations. Until syphilologists instruct physicians that the initial lesion is not infrequently a local manifestation of the generalized infection, and until they spread the knowledge that chance is not an integral part of syphilitic infection, cerebral syphilis will not be prevented.

(101) Treatment of a Case of Kala-Azar.

An Indian coolie, suffering from kala-azar, has been treated by A. Castellani (*Journ. of Trop. Med. and Hygiene*, May 15, 1915) with the "yaws" mixture, which contains tartar emetic, po-

tassium iodide, salicylate of soda and bicarbonate of soda. The patient, who was 22 years of age, had a low, irregular fever and a much enlarged spleen. He was very weak when he first came under observation. On splenic puncture, the material withdrawn contained large numbers of *Leishmania donovani*. The patient received three doses daily of the mixture on alternate weeks for two months. His condition improved greatly. In order to determine the active constituent in the mixture, he was then treated with intravenous injections of tartar emetic in Fowler's solution twice a week for three months. Later a solution of tartar emetic in water was injected into the veins every ten days. The improvement was remarkable. Castellani believes that the tartar emetic has been responsible for his improvement. After four months' treatment, splenic puncture revealed a diminution in the numbers of the parasites. At the end of six months, the patient, considering himself to be cured, ceased to present himself at the clinic.

(102) Intra-Thecal Injections for Syphilis of the Central Nervous System.

W. C. Stoner (*Cleveland Medical Journal*, June, 1915) has published a report of the treatment of sixteen cases of syphilis of the nervous system, by injections of standardized salvarsanized serum. His technique is as follows: He separates 15 c.cm. serum from 60 c.cm. of the patient's blood. To this serum he adds from one-fourth to one milligram of salvarsan from a freshly prepared solution containing 1 dg. in 40 c.cm. of distilled water. He maintains the mixture for three-quarters of an hour at 38° C., and for thirty minutes at 56° C. He uses the prepared serum at once. Fifteen cubic centimetres of cerebro-spinal fluid are removed, and the same amount of serum injected into the spinal canal. The patient is kept on his back for twenty-four hours. The cases treated have consisted of six cases of tabes, one of paresis, four of cerebro-spinal syphilis, three of cerebral syphilis, one of hemiplegia and one of syphilitic psychosis. The clinical improvement was in every case marked. He concludes that the intraspinal treatment is an adjunct in the management of syphilis of the central nervous system that has given us new hope.

UROLOGY.

(103) The Diagnosis of Prostatic Suppuration.

H. Brooks approaches the subject of the medical diagnosis of prostatic suppuration from the point of view of the general practitioner (*Med. Record*, July 17, 1915). He points out that suppurative prostatitis usually originates in a gonorrhœal urethritis. Not uncommonly the urethral discharge ceases at the time when the prostatic infection is developing. Under these circumstances, the association between the two conditions may not be apparent. Suppurative prostatitis may also arise

as a result of direct infection from a prostatic calculus, or as a result of a proctitis, cystitis, orchitis or vesiculitis. The infecting organism may be the colon bacillus or a member of the proteus group. Chronic constipation, especially when associated with hemorrhoids or fissures, may give rise to a hyperæmia of the gland, which, in its turn, leads to a suppurative prostatitis. A traumatic form is attributed to horse or bicycle riding on an improperly fitted saddle. In a certain number of cases the suppuration is secondary to suppuration situated elsewhere. The common association of the condition with prostatic hypertrophy is obvious. The author regards the prostate as an analogue to the uterus in the female, and explains on this ground the fact that relatively insignificant changes at times produce a profound influence on the body. In regard to symptoms, pain is usually present, but may be absent. Tenderness is more marked and more constant than pain. Tenesmus and reflex constipation may arise as the result of an obstruction in the urethra. The suppuration itself may lead to a chain of symptoms spoken of as typhoid. Fever is usually present, sweating is often profuse, and the pulse may be very suggestive of enteric fever. There may be a striking lack of localizing symptoms, which renders the differentiation between suppurative prostatitis and enteric or para-typhoid fever extremely difficult. The agglutination reactions, the negative results of endeavours to cultivate the typhoid bacillus and the discovery of the gonococcus, colon bacillus, or proteus may clear up the doubt. On the other hand, there is often nothing to suggest that the prostate may be affected. Miliary tuberculosis, simulating enteric fever, must be thought of in the differential diagnosis; and the doubt may be cleared off by an examination of the centrifuged deposit of the cerebro-spinal fluid for tubercle bacillus. In cases where the symptoms are of the typhoid type and enteric fever, para-typhoid, and tubercle can be excluded, a rectal examination should be carried out, in order that the condition of the prostate may be ascertained. The author appends the history of a case in which a difficult diagnosis was made in this manner.

(104) Acute Hæmorrhagic Nephritis in Children.

C. G. Grulee and F. W. Gaarde give the clinical histories of six cases of an acute nephritic condition occurring in children in which a local infection in the tonsil appeared to be the starting point (*Journ. Amer. Med. Assoc.*, July 24, 1915). In two of the cases the hæmaturia ceased almost immediately after the removal of the tonsil. Recovery followed in one child after the mastoid was drained. The infecting agents were *staphylococcus albus* and *streptococcus hæmolyticus*. In one instance the organism was recovered from the urine as well as from the throat. Usually the tonsillitis pre-

cedes the hæmaturia by about a week. The hæmaturia comes on suddenly, and is associated with albumin and casts in the urine. The temperature is raised to a moderately high level, and runs an irregular course. As the nephritic condition clears up the fever disappears. There is no disturbance of the general condition of the patient, save a slight amount of œdema of the eyelids at times. No symptoms associated with uræmia had been noted in connexion with these cases. The authors state that they have evidence that scarlatina could be excluded in every instance. In regard to treatment, they adopted the plan of dealing with the primary infection and giving hexamethylenamine in small doses.

(105) Gonococcal Vulvo-Vaginitis in Infants.

Vulvo-vaginitis may be due to a variety of organisms, but, unfortunately, in the large majority of cases occurring in children it is due to the gonococcus. Charles C. Norris deals with the diagnostic difficulty of this gonococcal form, and with the treatment (*Journ. Amer. Med. Assoc.*, July 24, 1915). During the acute stage of the attack, there is no difficulty in the isolation of the organism. When the disease has become chronic, and the discharge is scanty, it may be extremely difficult to demonstrate the gonococcus. Complement fixation and the cutaneous test are valueless in this connexion. The author calls attention to a method of determining the presence of gonococci, introduced in 1910 by Van Gieson. This consists in wiping the external genitalia with a swab immersed in a solution of mercuric chloride. Any discharge seen on the vulva is removed by scraping gently with a blunt spatula or knife blade. The material collected is utilized for making a smear, to be examined at once. Should the result be negative, the patient is placed in an elevated position, and about half an ounce of 1 in 5,000 solution of mercuric chloride in normal saline solution is injected into the vagina. The vagina is ballooned by the admission of air. A smooth glass rod is then applied to various parts of the vaginal membrane for the purpose of detaching any adherent secretion. The solution is then collected, and centrifuged at high speed, and the sediment examined in the usual way. Should this method prove negative, and especially when it is a question of discharging the patient as cured, the following method is recommended:—On the day prior to the bacteriological examination the entire vagina is painted with a solution of silver nitrate of 5 or 10%. On the following day washings are obtained, and gonococci will be found when all other methods yield a negative result. In regard to treatment, the author lays great emphasis on cleanliness. The treatment he adopts is based on the fact that dessication destroys the gonococci. This organism does not thrive on mature squamous epithelium. The patient is placed in the knee-chest

position, or in Sims's lateral position, or in the case of young infants, with the buttocks elevated by a nurse, and the vagina is ballooned until it is well distended. The hymen is destroyed, if necessary under cocaine anaesthesia. The vagina is washed with a weak solution of permanganate of potassium, it is then swabbed with a 25% argyral solution. After it has been dried as thoroughly as possible with gauze, the final step consists in flooding the vagina with a 1 or 2% solution of silver nitrate. This treatment is repeated three times a week, and in the interim the vagina is irrigated with weak potassium permanganate or argyral solution. The success of the treatment depends on its regularity and thoroughness. Before the treatment is finally interrupted negative findings should be obtained after three consecutive bacteriological and physical examinations at a fortnightly interval. Before the last examination chemical irritation with silver nitrate should be adopted.

(106) Cancer of the Bladder.

In dealing with the question of the treatment of malignant disease of the bladder, Henry H. Morton points out that every vesical tumour is potentially lethal (*Med. Times*, July, 1915). By this he means that a simple papilloma may become transformed into a malignant growth, or may kill the patient by hæmorrhages, or by ascending pyelo-nephritis. Bladder tumours can only be diagnosed by cystoscopic examination, and a differentiation between simple papilloma and carcinoma can only be arrived at by the microscope. The author proceeds to describe the various crude attempts formerly employed for the removal of cancerous tumour of the bladder. These attempts were followed by sepsis and speedy death. Incomplete operations proved so disastrous that European surgeons refrained from opening the bladder unless the neoplasm involved the dome or front wall only, or unless budding neoplasms caused retention of urine by clogging the neck of the bladder, or when an intervention became essential on account of repeated hæmorrhage. In the final stages of inoperable cases, the patient suffers from tenesmus, strangury, intense pain, and want of sleep. Some relief may be effected by one of the palliative operations for drainage of the bladder. Fulguration and radium are now being tried for this condition. The former yields good results in non-malignant growths, but is useless for carcinoma. The action of radium is uncertain. A more radical operation, consisting in an excision of the entire bladder wall for a wide area around the base of the tumour, is practised in some cases. The success of this method depends largely on the situation of the tumour. Unfortunately tumours are rarely situated favourably. The author concludes by inciting the general practitioner to carry out a cystoscopic examination in every case of hæmaturia, in order that an early diagnosis of cancer of the bladder may result in the saving of the patient's life.

MEDICAL EXAMINATION OF RECRUITS.

By Captain Hugh R. G. Poate.

No. 1 Field Ambulance, 1st Australian Division.

On reading the cables in a recent number of an Egyptian newspaper, it was with feelings of surprise and regret that I noticed, as the only news from Australia, the statement that "The height and teeth standards for recruits had been lowered," as well as some remarks from the Chief Justice, advocating the latter measure, on the ground that a large number of men had been rejected on account of defective teeth. This question of defective teeth in our men has assumed a great importance in the eyes of those who have been engaged both in looking after the health of our troops before and since entering the field, and in effecting the transport of sick and wounded from the scene of hostilities.

During the training period both in Australia and Egypt all ranks were advised, encouraged, and helped by their medical officers to have their teeth put in good condition. Even then men were found to have trouble in masticating ordinary food, and to suffer from alimentary derangements directly traceable to defective teeth.

From the point of view of utility on active service, this term "defective teeth" should be interpreted as including not only conditions of caries, *pyorrhœa alveolaris*, or deficiency in numbers, but also cases where extensive dental work has been necessary in the shape of bridge work, crowns and pivots, or big plates.

In the transport of sick and wounded from the front the inclusion of a large number of men who were necessarily sent back to the base simply because, having defective teeth, they were unable to eat sufficient of their rations to keep them in good condition, has caused much surprise. The army biscuit, renowned for its solidity, is the great stumbling block, and as it forms a large portion of the daily ration is essential that the men should be able to eat it. In many cases plates have been lost, broken or mislaid, leaving the individual with but a few teeth (in many cases none in the upper jaw at all), quite unable to do the work demanded of them. In other cases artificial teeth have become loosened, or bridge-work has been carried away, to the great discomfort and despair of the erstwhile owner. As an example of the number of men being returned for troubles of this kind, it may be stated that out of some 400 patients in the last batch passing through our hands, there were no less than 17 men whose sole trouble was teeth, or rather lack of effective teeth. This number does not include the cases of digestive troubles due to a similar want. Since so much trouble has been experienced with these men, who were recruited under fairly strict conditions, surely it would be more expedient for the future to consider this question of teeth very carefully rather than to lower what is already a low standard. No man should be accepted unless he has a sufficient number of sound teeth, especially molars, as would enable him to chew anything, without any assistance from artificial teeth.

This subject also opens the question as to whether it would not be advisable to attach one or more qualified dental surgeons, with trained assistants to each medical unit, their duties to include not only the keeping fit of healthy men, but to render very valuable assistance in many cases of jaw and mouth injuries. The New Zealand forces, as well as units from other parts of the world, have had provision made for a Dental Corps. The members of these corps have been kept busily at work.

The lowering of the height standard may be a good thing, provided that only men of the robust nuggetty build are signed on, for a full pack and full ammunition pouches are no load for slim shoulders to carry. In fact the "nuggets" often fare better than the lanky six-footers, whose chest measurements so often are not commensurate with their height. A few other questions, the result of practical experience, concerning recruiting from the medical point of view, may be touched upon in this place.

Particular attention should be directed to all cicatrices, operation or other, especially in the abdominal region. No lengthy or sketched scar should be passed, and as regards the abdomen, no case at all under 3 years since the operation, and only then if there has been complete freedom

from all signs or symptoms. Any suspicion of ventral, inguinal or other variety of hernia, as also chronic knee, ear or nasal trouble should prove a bar to enlistment.

Epilepsy, mental troubles, lumbago, rheumatism, or skin and chest troubles should be enquired after very carefully, and considered seriously, while any scoliosis or cardiac condition means a decided "No."

Varicocele and varicose veins are conditions which are difficult to form a judgement on. Slight cases may be passed, but any extensive case must certainly be refused.

Men who either have not fully matured, both in mind and body, or have abused their nervous stability by alcoholic or other excesses, are unable to stand the tremendous strain of the war conditions to be faced. Cases of exhaustion, collapse, nervous irritability, melancholia, and various forms of mania have been by no means uncommon, and their occurrence is only to be lessened by a strict adherence to a definite age limit, e.g., 21 to 40 years, and by careful medical examination in conformity with a prescribed standard.

In the majority of instances of officers and men reporting sick for one or other of the conditions mentioned the complaints are genuine enough, but there are some who either wish to shirk work, or, having had enough of it, want to get back. The men then begin to find out various convenient recurring ailments. As a rule it is impossible for a medical officer to swear the man is a malingerer, although he may have no doubt about it in his own mind, and has to give the patient the benefit of the doubt, and send him back from the spot where every available man is wanted, to increase the number of drones collecting at that place of mystery, ease and comfort, the Base!

Men usually tell us that they were hardly looked at by the medical examiner, and that they were very seldom questioned when they were accepted for service. Every medical man entrusted with the examination of recruits should realize that although the work is tedious, he has a very responsible duty to perform, affecting not only the efficiency of military units, but the welfare of the men themselves, and also the status of the medical profession in the opinion of the general public. The authorities should recognize this. If competent medical men were appointed solely for this work, at an adequate salary, to ensure all care being taken that only sound and healthy recruits are accepted for service overseas, a considerable financial saving would be effected. We have felt reasonable pride in the offer and acceptance of our assistance to the Mother Country, and up to the present it has been freely admitted that our men have been physically of the best. Why not maintain this original standard rather than lower it in any particular? Our men have done and are doing well. Our original division underwent a hard and long training, and if the reinforcements are to be of use in carrying on the strenuous work, it is essential that each man shall be physically fit in every respect.

—0—

British Medical Association News.

SCIENTIFIC.

A meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on August 29, 1915, Dr. George Armstrong, the President, in the chair.

Dr. E. T. Thring read a paper on "Notes on Malignant Disease of the Lower Bowel." The text of this article will be found on page 239 in this issue.

Dr. George Armstrong referred to a case of Sir Alexander MacCormick's, in which Dr. Crago had assisted at the operation. The operative treatment in this case of malignant disease of the lower bowel might well be described as a masterpiece. He hoped that Dr. Crago would give some account of this case. The patient had done extremely well. Shortly after the operation she became pregnant. She was delivered of a healthy child some two years ago. Both mother and child were well at the present time. Dr. Armstrong dealt with the advisability of preserving the anus and sphincter in cases of rectal carcinoma.

Dr. Flynn expressed his appreciation of Dr. Thring's instructive paper. He recalled a case of carcinoma of the sigmoid, which he had recorded some 12 months previously. In this case, as in Sir Alexander MacCormick's, the patient had become pregnant shortly after returning to her home. She had born a healthy baby. The cicatrix showed a slight hernia, but with this exception, she had remained well from that time to the present, a period of nearly 18 months. In turning to the question of the removal of malignant growths of the large intestine, two questions had to be taken into account: (i) Was there any obstruction? and (ii) What amount of bowel would have to be devitalized? It was recognized that when obstruction was present immediate suture should not be performed. On the other hand, in the absence of the signs of obstruction, especially if persistent diarrhoea were present, immediate suture could be undertaken with a reasonable prospect of success. The operation should be carried out in two stages; the first should consist in a preliminary colostomy, while the second should comprise of the removal of the growth. The second question was a pathological one. A considerable amount of work had been done in recent years of the lymphatic drainage areas in connexion with the intestines. Our knowledge had been greatly increased in regard to the lymphatic drainage of the colon by Mayo Robson, while Ernest Miles had contributed valuable data concerning the sigmoid and rectum. The interposed systems of the vessels of the colon occupied his attention for a few minutes. He then directed his remarks to the radical operation carried out by a ligation of the ileo-colic branches of the inferior mesenteric vessels. The first stage of the operation consisted in a mobilization of part of the colon and the removal of that part together with the growth. Although this was an ideal procedure, it should not always be followed. In cancer of the colon there were three lymphatic barriers. This fact was of considerable importance in the determination of the extent of the operation required in a given case. Colonic cancer was characterized by a long period of grace, and it might be better to do a moderately extensive excision than a radical removal of the whole area of possible growth. The *post mortem* evidence should be taken into consideration. Death was due more frequently to intestinal obstruction than to metastasis. Mayo Robson and Butlin had shown that metastasis was relatively rare in these growths. The extension of the growth took place first toward the prostate and then in the direction of the inferior mesenteric vessels. Dr. Flynn sounded a note of warning in conclusion. It was not admissible to compare cancer of the lower bowel with cancer of the breast, or cancer of the lip. He paid a tribute to Dr. Thring's warm enthusiasm of youth combined with the calmness of prolonged experience.

Dr. Crago was convinced that Dr. Thring could not have done more in the second case described. He felt that he had been more or less responsible for the employment of the drain. He spoke briefly of some cases in which he had assisted Sir Alexander MacCormick in the operations. Some of these cases were similar to those described by Dr. Thring. In the case referred to by Dr. Armstrong, the sphincter had been preserved, and the rectum divided close to the sphincter. Slight leakage and a little sloughing at times followed operations of this kind. This was dependent of the amount of tension to which the sutured bowel was subjected. In one case, the growth was found to be adherent to the bladder, and it had been necessary to excise part of the bladder wall with the growth. In another case, Sir Alexander MacCormick had refused to attempt the removal of the growth because the peritoneum was involved. The patient had died shortly after. When the peritoneum was involved in the process, no useful purpose was served by attempting to remove the tumour.

Returning to Dr. Thring's second case, he explained that the operation was most difficult, chiefly on account of the dense adhesions which had to be broken down. In general he had gained the impression that operations on the small intestine were more frequently fatal than operations on the large intestine.

Dr. Corlette had had recent experience of a case in which he had resected the coccyx and part of the sacrum, and had been able to get the affected part of the bowel out through this route. The bowel had been drawn down and

presented through the sphincter. In this case, the sphincter had not functionated properly afterwards. This was due to some damage inflicted on the innervation of the damaged muscle. Dr. Corlette referred to the chronicity of many cases of rectal cancer. Only a fortnight ago he had operated on a patient who had been sent to hospital five years before for malignant stricture of the sigmoid. The patient had been well during the interval, but obstinate constipation had compelled her to seek advice again. The obstruction was found at the splenic flexure. He had opened the abdomen through the old incision. The caecum was brought down and anastomosed to the pelvic colon. Later on he would make an attempt to remove the growth from the region of the splenic flexure. The patient looked fairly well. In another case, a growth had been present for four years. The patient was a woman. She had become pregnant subsequently to the operation. This was 10 or 12 years ago. He held the opinion that even when the primary growth was attacked, the glands could be left untouched. The patients might live for a very long time, in comparative comfort. An extensive, more radical operation was attended by greatly increased risk.

Dr. Binney thought that each case should be determined on its merits. In cases like Dr. Thring's first one, the less that was done, the better. He had found it a good working rule to go on with the operation if the peritoneum was free, but to leave things alone if the peritoneum was involved or infected. He asked Dr. Thring for information in regard to the nature of the growth in this case. Turning to Dr. Thring's third case, he suggested that a block operation had been performed, to which Dr. Thring nodded assent. Paul, when speaking at the Liverpool meeting of the British Medical Association, had pointed out that large, villous growths of the large intestine often caused obstruction rapidly. If removed freely, there was good chance of cure. On the other hand, growths of a scirrhus nature which involved the intestinal wall more extensively than the villous growths were far less satisfactory from the operative point of view. He considered that the double route was preferable in the majority of the cases.

Dr. Chenhall spoke of the need for an early recognition of cases of malignant disease of the pelvic intestines. He had dealt with the question of early diagnosis and operation in connexion with cancer of the breast, uterus and stomach in a paper communicated to one of the Australasian Medical Congresses. Non-recognition of these growths at a comparatively early stage of the disease had become a reflection on the skill of the practitioner. The early diagnosis of cancer of the lower bowel was a more difficult matter, but they would be much indebted to Dr. Thring if he would indicate to the practitioner how this might be arrived at. He was inclined to differ from Dr. Thring in one point in regard to technique. This was the question of drainage. He regarded when in doubt, drain! as a good axiom. He would require long experience and convincing proof to convert him to Dr. Thring's doctrines. He was quite prepared to recognize the value of leaving saline solution in the abdominal cavity; but even this did not, in his opinion, remove the necessity of draining in many cases.

Dr. Griffith spoke as a physician, and questioned the advisability of choosing what he deliberately called pathological methods of tracing the lymphatics. The anatomists had studied and described the distributions of the lymph vessels with great accuracy, and he quoted some elaborate researches on the anatomy of the lymphatics, which he would prefer to follow rather than Ernest Miles's work. In regard to early diagnosis, he pointed out that the fault lay in the fact that there was frequently nothing to lead the patient to recognize the necessity of consulting the surgeon during the early stages. He quoted a case to illustrate this point.

In his reply, Dr. Thring agreed with Dr. Armstrong's suggestion that it would be wise to save the sphincter if this were possible. To Dr. Flynn, he pointed out that in his second case the peritoneum did not encircle the bowel. The difficulty in dealing with cases in which the peritoneum could not be closed off was considerable. He laid great

stress on the fact that in his paper he had been dealing exclusively with growths involving the lower bowel, below the pelvic floor. The position was totally different from cancer affecting the large intestine in the abdomen. In casting a glance over Dr. Crago's remarks, he again agreed that it was desirable to save the sphincter if possible, although Miles would not assent to this course. He regarded Kraske's operation as unsatisfactory, and, in his experience, resection of the sacrum was rarely, if ever, necessary. He found comfort in Dr. Corlette's remarks, which strengthened him in his anticipation that his two surviving patients might escape recurrence of the growth, or at all events live for a considerable time in comfort.

Replying to Dr. Binney, he stated that fungating growths of the columnar-cell type, which were so frequently associated with free hæmorrhage, yielded better results than the more atrophic growths. In uterine cancer, which was the most analogous to the malignant growths of the lower bowel, it was rare to see a squamous epithelioma early enough to guarantee freedom from recurrence. In regard to technique, a preliminary colostomy often hampered subsequent work. The difficulty experienced in attempting to mobilize the affected part of the bowel after a colostomy was considerable. Referring to the question of early diagnosis raised by Dr. Chenhall, he pointed out that this was more difficult with growths of the lower bowel than when the large gut was the seat of cancer. Every case of obstinate constipation in patients over 40 years of age should be carefully investigated.

Dr. F. Guy Griffiths read a paper on "Summer Clothing for Sydney" (see page 241).

The discussion which followed was marked by the somewhat unusual length of the remarks of the various speakers, and by frequent indulgence in a light tone.

Dr. Arthur gave an account of his views on this matter. He drew attention to the foolishness of importing Old Country customs in so far as dress was concerned into Sydney. He emphasized the fact that the southerly wind, which was looked on as so deadly, was preceded by a very hot day in summer time, and the drop in temperature was sudden and severe. Men sweated freely during the hot part of the day, and the chilling was often extreme. He held the opinion that a considerable amount of nervous exhaustion and neurasthenia was due to overclothing in summer time. Woodward had said that the American soldiers in the Philippines were better protected from the sun if they wore thick, dark flannel shirts than light shirts. The proposal had been made that a black undervest would protect men against the effects of the sun's rays, even if worn under an ordinary shirt.

Dr. Litchfield challenged Dr. Griffiths in regard to his contention that the reason why sailors were less prone to pneumonia than soldiers was that they wore open tunics. He maintained that the sailor led a sea-life, and that pneumonia was a land disease. He considered that Sydney's was a very difficult climate to dress in during the summer months. Clothing depended on age and occupation to a large extent. In Brisbane, people wore duck and white helmets, but this form of clothing was not suitable for Sydney. The evidence of this was that it was not seen in Sydney. Dealing with the climate of Sydney, he spoke of the muggy weather associated with the north-east winds, the dry weather associated with the westerlies, and the cool weather associated with the southerlies. These weathers appeared almost in rotation. The north-easterly was usually followed by the southerly, and occasionally by the westerly. The north-easterly was not an unhealthy wind, and was not a pneumonia wind. Nor was the cool southerly. The wind which was associated with an infective process, namely diarrhoea, was the westerly. The pneumonia wind was the cool westerly. He therefore concluded that it was impossible to lay down rules as to how a man should clothe himself. If the extravagances of fashion were avoided, he thought that the present mode of dressing was fairly rational.

Dr. Chenhall advocated freedom of movement in clothing. He did not consider the question of material as equally important to that of looseness and proper shape. He made

some scathing remarks on the garments habitually worn by many golfers before their rounds and even during them.

Dr. Corlette doubted if the colour of a garment mattered, unless it was the only garment. He was convinced that the red flannel which some married women put on their husbands and children was the remnants of medical teaching of a bygone century. Many superstitions in medicine of to-day were the teachings of doctors of times long gone by.

Dr. Griffiths replied at some length, without adducing any new arguments. He did not admit defeat in regard to the question of pneumonia in sailors. He maintained that sailors on land duty were less frequently affected than soldiers.

—O—

Medical Matters in Parliament.

VICTORIA.

A bill to restrict the sale or consumption of intoxicating liquor during the present war was introduced on May 19, 1915, into the Legislative Assembly, by Mr. Murray and Sir Alexander Peacock. The bill read as follows:—

Be it enacted by the King's Most Excellent Majesty by and with the consent and advice of the Legislative Council and the Legislative Assembly of Victoria in this present Parliament assembled and by the authority of the same as follows (that is to say):—

1. This Act may be cited as the *Intoxicating Liquor (Temporary Restriction) Act, 1915*, and shall be read and construed as one with the *Licensing Act, 1890*, and any Act amending the same all of which Acts and this Act may be cited together as the *Licensing Acts*.
2. Notwithstanding anything in the *Licensing Acts*—
 - (a) whereby or pursuant to any provisions of those Acts or by any license or special permit heretofore or hereafter granted thereunder a time before the hour of nine o'clock in the morning or after the hour of half-past nine o'clock at night is prescribed as the earliest or latest time respectively at which liquor may be sold or disposed of in any licensed premises or club premises the said and all other provisions of these Acts and every such license and special permit shall be read and construed and given effect as if for such earliest time there were substituted the said hour of nine o'clock and for such later time the said hour of half-past nine o'clock; and
 - (b) the hours aforesaid shall not be extended under any powers contained in the *Licensing Acts*.
3. (1) This Act shall continue in operation during the currency of the present war and no longer.
- (2) The expiration of this Act shall not affect—
 - (a) the previous operation of or anything duly done or suffered under this Act;
 - (b) any penalty forfeiture or punishment incurred under this Act; or
 - (c) any investigation legal proceeding or remedy in respect of any such penalty forfeiture or punishment.

And any such investigation legal proceeding remedy may be instituted continued and enforced and any such penalty forfeiture or punishment may be imposed as if this Act had not expired.

On May 20 the Chief Secretary, Mr. Murray, moved the second reading of the bill. He said the bill was the outcome of a desire on the part of the majority of the public to limit the hours during which drink could be consumed. Their consciences had been awakened by the recent excessive drinking. He thought that early and late drinking was most pernicious, and did most harm to the community. He hoped the Act would diminish the consumption of liquor.

The debate was adjourned for a week.

Mr. Farthing was of opinion that the position in Great Britain did not obtain here. The people were not drinking more. The trade in drink had gone down. There was no complaint against the workers. The bill would not diminish

drinking at all. The passage of the bill would interfere with the travelling public. He thought the objects of the bill could be reached by extending the scope of the Licenses Reduction Board. It could be given power to limit the hours for hotels in places where special war conditions held.

Mr. Rouget considered that the bill did not go far enough. He thought that the hours should be further limited.

Mr. Billson challenged the Government to produce any statistics to show that the people of Victoria were addicted to excessive drinking.

Mr. Elmslie would support the reduction in the number of hours, but hoped that it was not intended to make the measure a permanent one. He advocated some compensation to the holders of licenses for the loss in revenue that they might experience from the operations of the bill.

Mr. Snowball thought the action of the bill should not be limited to the period of the war.

Mr. Hogan advocated the nationalization of hotels.

The Premier outlined certain amendments to be submitted in committee, and the second reading was carried.

The House went into Committee, and the first clause was agreed to.

The discussion in Committee was resumed on June 1, when clause 2 was considered. Mr. Bowser moved to omit the words "special permit," so that the refreshment rooms on railway stations might sell liquor under special permits. The amendment was rejected after a long discussion. Mr. Blackburn moved to insert six in place of half-past nine. The amendment was negatived by 50 votes to 4. A further amendment to omit the word "nine" was also lost. Clause 2 was then agreed to.

The Chief Secretary then moved two new clauses, which were agreed to. They read as follows:—

A. (1) (a) Any person (except the occupier or any member of his family dwelling on the premises or any of his servants) who between the hours of 9.30 o'clock at night and 9 o'clock next morning drinks liquor (as defined by section 3 of the Licensing Act 1890) in or on any unlicensed premises shall for every such offence be liable to a penalty not exceeding £2.

(b) Any person who permits or allows any liquor as so defined to be drunk (unless by any of the persons so excepted) on his unlicensed premises between the hours aforesaid shall, for every such offence, be liable to a penalty of not less than £5 or more than £20, and for every subsequent offence to a penalty of not less than £25 or more than £50.

(2) For the purposes of enforcing the provisions of this section any member of the police force may at any time between the hours aforesaid demand entrance into any unlicensed premises or the appurtenances thereof, and if admittance is delayed for such time as that it may be reasonably inferred that wilful delay was intended, the offender shall be liable to a penalty of not less than £2 or more than £10; and if such admittance is refused or wilfully delayed such member of the force may break into such premises.

(3) In this section "unlicensed premises" means any premises where meals or refreshments are ordinarily sold or disposed of to the public for consumption on the premises, and without affecting the generality of this definition includes any café, restaurant, oyster saloon, or other eating house for which a victualler's licence or an Australian wine license is not in force, and any premises which the occupier of such unlicensed premises is permitted to use or uses for the purposes of or in connexion with his business.

(4) Nothing in this section shall make lawful anything which would have been a contravention of any of the provisions of the Licensing Acts if this Act had not passed.

B. At the end of section 164 of the *Licensing Act 1890* there shall be inserted the following words:—"Notwithstanding anything in any Act or any law to the contrary a warrant granted under the provisions of this section may be executed at any time by day or by night."

C. In section 182 of the *Licensing Act, 1890*—

(a) for the words "one month" there shall be substituted the words "three months"; for the words

"three months" wherever occurring there shall be substituted the words "six months"; for the words "six months" there shall be substituted the words "twelve months"; and for the words "one year" there shall be substituted the words "eighteen months";

(b) at the end of the said section 182 there shall be inserted the following words:—

"Proof of consumption or intended consumption of liquor on any premises by any person other than the occupier of such premises shall be *prima facie* evidence in any proceedings under this section that such liquor was sold to the person consuming or being about to consume or carrying away the same as against the occupier of the said premises."

Other amendments were proposed, but the Deputy Chairman ruled them out of order, whereupon the House adjourned.

On June 9 the House again went into Committee, and the Bill was reported with amendments.

On June 10 Sir Alexander moved the third reading, which was agreed to, with an amendment allowing liquor to be served with meals on board ship:—

(2) C. It shall not be lawful for the master of any vessel being a vessel by which passengers are conveyed from any place within Victoria or its dependencies to any place within Victoria to sell or dispose of liquor on Sundays.

The Bill was received in the Legislative Council on June 15. The second reading was taken the next day, when the debate was adjourned for a week. On resuming the second reading was carried after a lengthy debate. The Council then went into Committee, when clause 1 was agreed to. Clause 2 was amended by substituting the word "latest" for "later." Clauses 3, 4 and 5 were then agreed to.

The Hon. R. B. Rees moved a new clause to declare any person convicted of selling liquor without a license or of being the occupier or keeper of premises reputed or believed to be premises in which liquor is sold or kept for sale, an idle and disorderly person within the meaning of the *Police Offences Act*. The amendment was lost on division.

The Hon. D. E. McBryde proposed the following new clause:—

Notwithstanding anything contained in section 135 of the *Licensing Act 1890* no person who resides within the Metropolitan district as defined by section 77 of the *Factories and Shops Act 1912* shall be deemed a bone-fide traveller within the meaning of section 134 of the *Licensing Act 1890* unless such person shall have travelled on the day on which he is supplied with liquor from a place distant at least twenty miles in a direct line from the licensed premises where he is so supplied.

The clause was agreed to.

The Hon. F. Hagelthorn then proposed the following clauses:—

(1) The operation of this Act shall not be held to prevent a licensed victualler from permitting or allowing any billiard or bagatelle table on his licensed premises nor in the bar thereof to be used between the hours of half-past nine and eleven at night except on Sundays.

(2) Save as expressly provided in this section nothing in this section shall make lawful anything which would have been a contravention of any of the clauses of the Licensing Acts if this section had not been passed.

The Hon. W. S. Manifold moved to add the words "or any sample room" after the word "premises." The amendment was agreed to, and the clause as amended was adopted.

The Bill was then read a third time and passed.

On June 29 this Bill was returned from the Council to the Assembly with a message intimating that the Council had agreed to the same with amendments.

On consideration of the Council's amendments it was decided to adopt the sixth clause with the omission of the words "who resides within the metropolitan area as defined by the *Factories and Shops Act 1912*."

In regard to the seventh clause it was adopted, with an amendment as follows:—The omission of the words "or any sample room" and the insertion of the words "or to prevent

the proper use of any room set apart for the storage of commercial travellers' samples."

On June 30 the Council agreed to the amendments made in the Assembly.

On July 13 it was reported to the Assembly that his Excellency had notified his assent to the Bill.

Public Health.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending September 2, 1915:—

	Metro-politan.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	51	1	21	1	72	2
Scarlatina	7	0	4	0	11	0
Enteric Fever	1	0	—	—	1	0
Pulmonary Tuberculosis	18	8	7	2	25	10

The following is a return of the cases of epidemic cerebro-spinal meningitis notified to the Board during the week ending September 2, 1915:—

	Metropolitan Area.		Rural Districts.		Totals.	
	Cases.		Cases.		Cases.	
Military	—		—		35	
Civilian	27		10		37	

SMALL-POX IN NEW SOUTH WALES.

The following cases of small-pox have been reported to the Department of Public Health, New South Wales, during the week ending September 5, 1915:—

Country—Newcastle and District	Cases.
	12

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending August 28, 1915:—

Disease.	No. of Cases.
Diphtheria	21
Varicella	15
Pulmonary Tuberculosis	10
Enteric Fever	5
Erysipelas	5
Scarlatina	2
Malaria	2
Puerperal Fever	1
Cerebro-Spinal Meningitis	4
Total	65

Vital Statistics.

VITAL STATISTICS OF SOUTH AUSTRALIA.

The Statistical Register of South Australia for 1914 has been presented to both Houses of Parliament. Part II. deals with the vital statistics and contains a large amount of important information.

During the year 12,905 births have been registered in the State. Of this number, 1,139 took place in the city of Adelaide, 5,380 took place in the suburbs of Adelaide, and 6,386 took place in the extra-metropolitan districts. The birth-rate per 1,000 of population is 29.33. This rate is the highest during the decennial period 1905-1914. The rate has risen from 24.54 to its present height by steady yearly increments.

No records dealing with the number of illegitimate births are published.

The number of deaths of children under one year of age was 981. This number yields an infantile death-rate of

76.01 per 1,000 births. In 1905 the infantile death-rate was 72.8, in 1910 it was 70.11 and in 1913 it was 70.08.

The number of marriages celebrated during the year 1914 was 4,009. In the decennial period, the numbers have varied within a not inconsiderable range. The variations are best recognized in the marriage-rates per thousand of population. In 1905 it was 7.21, in 1907-1909 it varied around 8.35, in 1910 it was 9.21, in 1911 it was 9.81, in 1912 it was 9.62, in 1913 it was 9.44 and in 1914 it was 9.11. One girl of over 13 and under 15 years was married. Four girls were 15 years of age at the time of marriage, 23 were 16 years, and 84 were 17. Five of the bridegrooms were only 17 years of age, 20 were 18, 36 were 19, and 110 were 20 years of age. At the other end of the scale, 62 males and 37 females were 45 years of age at marriage, 46 males and 20 females were 50, 31 males and 10 females were 55, 20 males and 8 females were 60 years of age, 8 males and 4 females were 65 years of age, and 6 males and 2 females were 70 years of age or more at the time of the marriage. A widower married a spinster in 162 instances, a widower married a widow in 71 instances, a bachelor married a widow in 101 instances, and in 3,675 instances neither party had been married before. Thirty-six of the contracting parties were unable to sign their names. No details as to the fertility of the unions or the proportion of second or subsequent marriages are given. In the absence of these figures, the full significance of the available data is greatly limited.

The third chapter of the statistics deals with deaths and their causes. The number of deaths registered during the year was 4,713. The excess of births over deaths has increased during the previous ten years from 1071 to 8192. With the exception of the year 1906, this increase has been steady and regular. The death-rate for 1914 was 10.71 per 1,000 of population. In spite of the improvement in hygienic conditions and of legislative and sociological endeavours, the death-rate curve tends rather in an upward than in a downward direction. The years 1909, 1910 and 1911 were characterized by the lowest death-rate in the ten-year period, being 9.74, 10.09 and 9.82 respectively. In 1905 the rate was 10.45, and in 1906 it was 10.66. From this year it decreased, to rise again in 1912 to 10.28. The maximum was reached in 1913, when it was 10.82, and in the year under review a slight improvement was registered in the figure 10.71.

Of the 4,713 deaths, 981 affected individuals under one year of age, 462 were over one and under 20 years of age, 700 were over 20 and under 40, 812 were over 40 and under 60, 1,262 were over 60 and under 80, and 496 were 80 or more.

The causes of death are tabulated in the usual manner, and, as has repeatedly been pointed out in these columns, much difficulty is experienced in analysing the figures with a view of ascertaining the effect of prophylactic measures. Turning first to the infective processes, and including all the cases which are usually recognized as being due to an infective organism, the following figures are found: Tuberculosis, 331; diarrhoea and enteritis, 471; pneumonia (? lobar), 200; chronic bronchitis, 93; acute bronchitis, 86; broncho-pneumonia, 65; enteric fever, diphtheria and simple meningitis, 57 each; pertussis, 47; influenza, 24; pleurisy, 18; acute endocarditis, 16; tetanus and syphilis, 15 each; acute articular rheumatism, 14; acute nephritis, 12; morbilli, 11; dysentery, 9; septicæmia, 7; erysipelas, 5; encephalitis and pericarditis, 3 each; and scarlatina, 2.

The diseases affecting the vascular system led to death on 762 occasions. Of these, 161 were instances of cerebral hæmorrhages, 475 were instances of chronic cardiac disease, and 49 were cases of atheroma, aneurysm, etc. Closely related to this group is that of Bright's disease. There were 205 deaths caused by this condition.

The number of deaths associated with pregnancy and the puerperal condition was 59. In 29 of the cases, the cause of death was puerperal septicæmia, in 11 it was puerperal albuminuria (probably eclampsia), and in the remaining 19 cases it was some accident or unavoidable pathological condition.

Information is appended in regard to the number of deaths from various causes in Adelaide, and the number which took place in institutions.

The vaccination returns are most alarming. There were 12,905 births registered during the year. In the same period, only 940 children were vaccinated. To perform this pro-

tective operation, 220 public vaccinators are appointed, and the State is satisfied to expend but £290 on the prevention of variola. During the ten years from 1905, the percentage of children vaccinated has varied from 34.37 (in 1907) to 7.28 (in 1914). The second highest rate was 17.08% in 1910, while in the remaining years the figure varied between 10.99% and 15.4%, save in 1912, when it was 8.57%. The population of South Australia must thus be regarded as inefficiently vaccinated.

SOUTH AUSTRALIA.

The returns of births and deaths in South Australia for the month of July, 1915, have been published in the South Australian Government *Gazette* of August, 1915. During the month 1,033 births were registered, which is equivalent to an annual birth-rate of 28.08 per 1,000 of population. This rate is lower than that registered in July, 1914, which was equivalent to an annual rate of 31.8 per 1,000. The Statistician does not give the figures of the illegitimate births.

There were 394 deaths registered during the month, which is equivalent to an annual death-rate of 10.68 per 1,000 of population. The equivalent death-rates for July in the preceding five years were 8.4, 10.2, 11.4, 11.88, and 12.36. The number of children under 1 year of age whose deaths were registered during the month was 55. This is equivalent to an infantile death-rate of 53.24 per 1,000 births. Of the 394 deaths, 157 affected persons of 60 or over, and under 45% of the persons dying between the ages of 5 and 60.

Infective diseases caused 112 deaths; tuberculosis was responsible for 45, of which 35 were instances of pulmonary tuberculosis. There were 17 deaths from bronchitis, 14 from pneumonia, 10 from diarrhoea and enteritis, 6 from diphtheria, 5 from simple meningitis, 4 from puerperal septicæmia, 2 from enteric fever, and 2 from acute articular rheumatism, and 1 each from morbilli, scarlatina, tetanus, simple septicæmia, pleurisy, and acute nephritis. Diseases of the cardio-vascular system caused 72 deaths, including 41 from chronic endocarditis, and 22 of apoplexy. Malignant disease was responsible for 31 deaths. Of the 29 deaths due to conditions affecting infants, 19 are ascribed to prematurity, 11 to congenital debility, icterus, etc., 7 to congenital malformations, and 2 to other diseases peculiar to infancy.

Separate returns are given for Adelaide, and for the various wards of the city. The total population of Adelaide is estimated at 43,428. The density of population is given at 11.5 per acre. There were 79 births registered during the month in the six wards of the city, which yields an equivalent annual birth-rate of 21.81. Of the 79 infants born, 38 were male and 41 female. The number of deaths registered was 54, 29 of males and 25 of females. The equivalent annual death-rate exclusive of deaths in public institutions of persons not usually resident in the city was 14.88. The lowest death-rate was in the ward of Grey, which, curiously enough, had the greatest density of population (16.6 per acre). In this ward the death-rate was equivalent to an annual rate of 9 per 1,000. In Robe ward, where the density of population was 6.4, the equivalent annual death-rate was 24.36. It thus appears that the highest death-rate is recorded in the ward with the smallest number of persons per acre, and the lowest death-rate in the ward with the greatest density of population.

The number of deaths is too small to admit of an analysis according to the causes. On the other hand, it is satisfactory to note that no deaths were registered under the rubric of the notifiable infective diseases (save pulmonary tuberculosis).

Hospitals.

ST. VINCENT'S HOSPITAL, SYDNEY.

The annual report of the Sisters of Charity, dealing with the accounts and statistics of St. Vincent's Hospital, Sydney, for the year 1914 has just been issued. The report is embellished by a number of excellent photographs illustrating various portions of the institution.

There were admitted into the hospital 2,995 patients during the course of the year. On December 31, 1913, there were 136 patients under treatment, and on December 31, 1914, there were 134. It may therefore be assumed that, for statistical purposes, 2,997 cases were treated. The usual mistake is made in the calculation of the case mortality. The mortality for the year works out at 4.425%, instead of 4.24%, as entered in the report. The number of patients discharged "cured," "relieved" and "unrelieved" is given. The entries stand in the following proportion: "unrelieved," 1; "relieved," 16; and "cured," 88. In the absence of details, especially as to the exact definition of cure, these figures are of little value. Under the heading cancer the following entries are made: The total number of cases treated was 94. The number discharged under the rubric "recovered" was 53, the number of cases discharged under the rubric "relieved" was 20, and the number of patients discharged under the rubric "unrelieved" was 5. Fourteen patients died, and two were still under treatment at the end of the year. It thus appears that 53 of 92 patients, or 57.6%, were regarded as cured of cancer on their discharge. It need hardly be pointed out that what is really meant is that the patients were discharged temporarily relieved of their malignant growth, but certainly not cured. In the same way it is obviously misleading to record recovery in three cases out of 38 of organic disease of the heart, or of four cases out of 8 of locomotor ataxy.

During the year, 70 cases of tuberculosis, 53 of enteric fever, 42 of influenza, 58 of acute articular rheumatism, 113 of syphilis, 18 of acute endo-carditis, 28 of diarrhoea and enteritis, 24 of septicæmia, 3 of malaria, 2 of dysentery, and 1 of diphtheria were treated in the wards. Of the diseases of the cardio-vascular system, in addition to the acute endo-carditis cases, there were 38 cases of chronic heart disease, 2 of acute pericarditis, 7 of atheroma, 4 of aneurysm, 4 of cerebral hæmorrhage, 4 of embolism and thrombosis, and 105 of varices, hæmorrhoids, phlebitis, etc. The number of patients admitted for appendicitis and typhilitis was 264. Twelve patients were still under treatment at the end of the year. Six of the patients died. This gives a case mortality for the series of 252 patients of 2.38%. It appears that 300 patients were subjected to the operation of appendicectomy, and that 6 died. This yields an operation mortality of 2%. The discrepancy between the number of cases of appendicitis and that of patients operated on for this condition is not explained. It would be interesting to learn whether a wrong diagnosis was made in the 36 or 48 cases. Hernia and intestinal obstruction were dealt with on 123 occasions. An operation was performed 119 times for hernia, and 3 patients died. The number of deaths from this condition and from intestinal obstruction was 7. It is impossible to trace the cases of intestinal obstruction subjected to operation in the list of operations. It would be of greater use if the results of operations were tabulated under the diseases for which they were undertaken, instead of being grouped according to the operation itself.

A special table is devoted to the number of patients who received treatment in the out-patient and casualty departments, and to the number of attendances given. This information we presume may interest the lay public. It does not interest us.

A new department for the treatment of mental and nervous diseases was established during the year. No details are given of the method adopted in this department. Brief accounts are appended of the work carried out in the various special departments. In the X-ray Department, Dr. C. Ayres points out that an increased number of cases were dealt with diagnostically, and that some interesting skin affections were treated by radiation. In the Department of Pathology and Vaccine Therapy, tuberculin was administered to 46 patients. No details as to the ultimate result of this treatment are given. In the Radium Department, 60 patients were treated with radium, the majority of whom was suffering from rodent ulcer. Dr. Langlosh Johnston reports that his department is greatly hampered by an inadequate supply of radium.

It is recorded that Sir Alexander MacCormick, Dr. Herbert Moran, Dr. Reginald Davies, Dr. A. Oswald Howse, Dr. John Storey, Dr. Stuart MacKenzie, Dr. Cuthbert Verge

and Dr. Eustace Pinhey were granted leave of absence for the purpose of enabling them to proceed to the front. Drs. Tansey, Mobbs, Dunn and Keith Smith were appointed temporarily to the honorary staff.

The maintenance account reveals that the sum of £11,619 was expended on maintenance during the year. There were 2,997 patients treated. It therefore appears that the cost per patient per annum was £3 17s. 6d. Unfortunately, no entry is made in regard to the average daily number of patients in hospital. The patients contributed £3,646, which is equal to nearly £1 4s. 4d. per patient. Donations amounted to £4,847, and £750 was derived from the Hospital Saturday Fund.

The Sisters of Charity issue an appeal for increased support to the hospital. In common with other hospitals and charitable institutions, the finances of the St. Vincent's Hospital have been seriously affected by the war.

THE QUEEN'S HOME, ROSE PARK, SOUTH AUSTRALIA.

The Queen's Home Incorporated is a maternity home for married women, and provides for the reception, care and treatment of patients about to be confined, and during, and subsequent to confinement, for the nursing and care of infants born of these patients, for the education and training of nurses in the special duties of midwifery and obstetric nursing, and for such other similar objects as may be determined on by the managers. The patients are admitted on the recommendation of a subscriber, minister of religion, or registered medical practitioner. The Committee will only accept patients who are in need of charitable relief. Under certain circumstances a fee of one guinea per week is charged. Patients are required to pay a booking fee of 5s when their application for admission is approved, and also to pay two weeks' maintenance in advance on entering the home. Every patient must produce her marriage certificate.

During the year 330 women were admitted into the Home, 80 of whom came from country districts. Of these patients 308 were confined. In 50 instances the parturition was abnormal. In addition 28 infants were admitted at the request of the State Children's Department. No details of the obstetric work are included in the report.

The Home was used as a training ground for 15 medical students and for 11 nurses. One missionary student completed a course of training during the year. Dr. T. G. Wilson and Dr. H. K. Fry were granted leave of absence for the purpose of joining the Expeditionary Forces, and Dr. R. J. Verco was appointed temporarily to the position of Honorary Assistant Medical Officer.

From the financial statement it is seen that there was a deficiency on the year's work of £37. The President, Mr. W. Herbert Phillips, made an appeal for an increase of the Government grant, which now stands at £400 per annum.

Naval and Military News.

It is with great regret that we have to record the death of Major J. F. G. Luther, which occurred as the result of wounds received in Gallipoli.

The death from wounds received in France on August 28, 1915, of Lieutenant Charles Montague Harris, R.A.M.C., has been announced in the daily press. Dr. Harris was the son of Mr. and Mrs. Henry Harris, of Enmore, Sydney, and the brother of Dr. S. Harry Harris. He graduated at the Sydney University this year, and proceeded to England, where he obtained a commission as lieutenant in the R.A.M.C.

The following casualties appeared in the list published in England in the last week of July, affecting members of the Royal Army Medical Corps:—

Killed: Captain J. Fitzgerald Gwynne, M.B., R.A.M.C. Dr. Gwynne was a graduate of the Sheffield University, having taken his degree in 1911. He served for a time as Resident Medical Officer at the Sheffield Royal Infirmary, and as Assistant Medical Officer at the South-wark Infirmary, in East Dulwich.

Lieutenant-Colonel W. Bridgett Pritchard, M.R.C.S., L.R.C.P., 2nd East Lancashire Field Ambulance, T.F. (died of wounds).

Wounded: Lieutenant O. H. Blackley, M.D., R.A.M.C., 3rd East Lancashire Field Ambulance, T.F.; Lieutenant F. C. Bentz, R.A.M.C., 2nd East Lancashire Field Ambulance, T.F.; Lieutenant C. D. V. MacCormack, R.A.M.C.; Major D. R. Taylor, L.R.C.P., L.R.C.S. (Ed.), L.R.F.P.S. (Glas.), attached 4th K.O. Scottish Borderers, T.F.

In the *London Gazette*, July 24, 1915, it was announced that Lieutenant William Kelsey Fry, R.A.M.C., had been awarded the Military Cross "for conspicuous gallantry and devotion to duty at Festubert between May 16 and May 18, 1915, while carrying out his work under heavy fire. He was himself wounded while attending to others." Lieutenant David James Sheires Stephen, M.D., R.A.M.C., has also been awarded the Military Cross "for conspicuous gallantry and devotion to duty in attending to the wounded under heavy shell fire on several occasions, notably on the night of April 23 and on May 8, 1915. He has usually performed his gallant work single-handed, and by his cheerfulness and pluck has encouraged all around him."

We are pleased to note that attached to the casualty list issued on September 6, 1915, the announcement is included that Major A. Graham Butler, who was reported ill, has recovered, and is returning to duty.

The sudden death of Dr. Ferdinand Campion Batchelor, of Dunedin, will be very widely regretted throughout Australasia. Dr. Batchelor served as Lieutenant-Colonel with the New Zealand Expeditionary Forces, and returned recently from Egypt on account of illness contracted at the front. We hope to be in a position to publish an account of Dr. Batchelor's career in an early issue of *The Medical Journal of Australia*.

Our attention has been called to the action of the Defence Department in regard to the Base Hospital, Melbourne. The Minister has intimated that he would accept the service of civilian practitioners to attend soldiers in the out-patient department of the Base Hospital. Men undertaking this duty will not be given military rank, and will receive no remuneration. Applications for the positions should be made to the Registrar, Major Berry. It would appear that the services of a number of practitioners are sought, and it is hoped that volunteers will be available within a short time.

MILITARY FORCES OF THE COMMONWEALTH.

Appointment.

His Excellency the Governor-General, acting with the advice of the Federal Executive Council, has been pleased to approve of the following change, etc., in connexion with the Military Forces of the Commonwealth, viz.:—

Australian Army Medical Corps—

Major F. A. Maguire, from Australian Imperial Force, to be Staff Officer to Director-General Medical Services (temporarily), with pay, consolidated, at rate of £550 per annum, inclusive of all allowances except travelling.

The following notices have been gazetted under date of August 25, 1915:—

Army Medical Corps—

The appointment of Captain F. H. Hayes is terminated.

Naval Reserve Forces—

Appointments—

Herbert Grindell Hurrey, M.B., B.S., is appointed Surgeon.

Frederick Glover Neason Stephens, M.B., F.R.C.S., is appointed Surgeon in the Royal Australian Naval Reserve (O).

Promotions—

The following promotions are made in connexion with the Royal Australian Naval Reserve:—

To be Fleet Surgeon—

Staff Surgeon Harry Paynter Sloggett, R.A.N.R.

To be Staff Surgeons—

Surgeon William Arthur James, R.A.N.R.
Surgeon Francis Wilson, R.A.N.R.

Extension of Appointment, etc.—

The period of service of Staff Surgeon Francis Wilson, in the Royal Australian Naval Reserve, is extended for twelve months as from 22nd June, 1915, and he is appointed as Acting District Naval Medical Officer (temporarily), Brisbane, as from 15th July, 1915, with allowance at the rate of One hundred and fifty pounds (£150) per annum, during the absence on other duties of Fleet Surgeon Archibald Birt Brockway, R.A.N.R.

Resignation—

The resignation of Surgeon Cyrus Retallack, R.A.N.R. (O), is accepted.

New Zealand Medical Corps—

Captain Joseph Patrick Frengley, M.D., F.R.C.S.I., D.P.H., is granted the temporary rank of Lieutenant-Colonel whilst employed on special duty at Trentham Camp.

Captain Hugh Earnshaw Finch, M.B., is granted the temporary rank of Major whilst employed on special duty at Trentham Camp.

Captain Sydney Smith M.D., is granted the temporary rank of Major whilst employed on special duty at Trentham Camp.

The following has appeared in the Commonwealth Government *Gazette* under date of August 21, 1915:—

To be Lieutenant-Colonel—

Lieutenant-Colonel J. F. Flashman, Sydney University Scouts.
Archibald Birt Brockway.
Robert Gordon Craig.

To be Majors—

Honorary Major W. A. Wood, A.A.M.C. Reserve.
Honorary Major J. A. G. Hamilton, A.A.M.C. Reserve.
Captain D. H. E. Lines, A.A.M.C.
Captain E. B. Allen, A.A.M.C.
Bronte Smeaton.
Arthur Edward Mills.

To be Captains—

Captain W. L. Kirkwood, A.A.M.C.
Captain (provisional) D. D. Cade, A.A.M.C.
Captain (provisional) W. Vickers, A.A.M.C.
Captain (provisional) F. H. Sabiel, A.A.M.C.
Honorary Captain J. B. Lewis, A.A.M.C. Reserve.
Honorary Captain N. C. Shierlaw, A.A.M.C. Reserve.
Robert Joseph Taylor.
John Howard Leon.
George Seaborne Robinson.
Arthur Edmund Colvin.
William Henry Rennick.
William Wallace Stewart Johnston.
Duncan Glenierochie Robertson.
Austin Sydney Curtin.
Frank Payne Edwards.
Bryan Foster.
John Sandison Yule.
John Joseph Power.
Eric Reay Mackay.
James Thomson Paton.
Edward Hamilton Rutledge.
Douglas Dunbar Jamieson.

To be Major, with pay of Captain—

Honorary Major C. A. Edwards, A.A.M.C. Reserve.

To be Captains—

Honorary Captain H. Stoker, V.D., A.A.M.C. Reserve.
Honorary Captain C. P. W. Dyring, A.A.M.C. Reserve.
James Burleigh Bell.
Arthur Hunter Powell.
Samuel Charles Fitzpatrick.
Ivan Blaubaum.
Joseph Horace Downing.
Jack Roland Stanley Grose Beard.

Charles Trevor Turner.
William James Connolly.
William Henry Weston.
Alexander Campbell Smith.
Leslie St. Vincent Welch.
Keith Harvey Grieve.
Horace Pern.

The following appointments have been gazetted:—

To be Captains—

Captain R. L. Rosenfield, Australian Army Medical Corps.
Captain (provisional) J. Sprent, Australian Army Medical Corps.
Honorary Captain F. Howson, Australian Army Medical Corps Reserve.
Claude Seccombe Browne.
William Ernest O'Hara.
Ronald Lennox Henderson.
Frederick Maurice House.
Roy Coupland Winn.
Horace Leigh Deck.
Edwin Weidenbach Arnold.
Hubert Richard Joseph Harris.
James Aiken.
George Charles Willcocks.
Sydney Herbert Allen.
Justinian Valentine Griffith.
Hugh William Fancourt Mitchell.
John Henry McGee.
Kenneth Stuart Cross.
Kenneth Rodas DeVaignes Shaw.
Robert Maxwell McMaster.

THE TRENTHAM COMMISSION.

The report of the Royal Commission appointed to enquire into the conditions obtaining at the Trentham Concentration Camp in New Zealand has been completed, and will be issued to Parliament in a few days. It is reported in the *New Zealand Herald* that the Minister for Defence is satisfied that the camp is suitably situated, suitably equipped and suitably arranged. He opposes the suggestion that the camp should be removed. It will be interesting to follow the course of events in New Zealand in the light of the recommendations included in the report of the Royal Commissioners.

Obituary.

ARCHIBALD SCOT SKIRVING.

The waste of valuable young lives during the great war now raging in Europe has no compensation. It is appalling. The Empire is the poorer by hundreds and thousands of men whose early career promised great things for the future. A fresh instance of intolerable waste has occurred in the death of Captain Archibald Scot Skirving, the second son of Dr. R. Scot Skirving, to whom our sincere sympathy goes out. His name is now entered in the roll of honour. He has died, as he lived, doing his duty, without consideration of self and without hesitation as to the path he should take. Those who knew him and his qualities would fain have held him back from the deadly risk of Turkish bullets, to gain for the world the work of which he was capable, and to win for his friends the companionship of the man they loved so well.

Archibald Scot Skirving was born in Sydney in 1891. He was educated at the Sydney Grammar School, where he gained distinction as a scholar and as an athlete. He was an enthusiastic cadet while at school, and developed, at an early age, a taste for military work, which increased in later years.

His medical studies were conducted at the Sydney University. He was a great favourite among his colleagues, and a chosen pupil of his teachers. To his and their credit, he gained distinctions at his final examination, and graduated with honours in 1911. While a student, he joined the University Scouts, and became a non-commissioned officer. After graduating, he served as a resident medical officer at

the Royal Prince Alfred Hospital. Later he became Sir Alexander MacCormick's and Dr. Foreman's house surgeon, and still later Dr. Rennie's house physician. In all these positions he gained the full confidence of his seniors, and earned for himself a reputation of an exceptionally smart and promising practitioner. When this period of service as house physician had termination, he journeyed to England, to widen his views on surgery and to gain an extended experience. He was occupied in London in this manner, when the war broke out. During his brief stay in London, he had obtained a commission in the Scottish Rifles. In August of last year, he underwent further military training, and, at a later date, obtained a commission as Captain in the 5th Royal Irish Fusiliers. The rest has already been recorded in the pages of this journal. He was sent to Turkey with his regiment, and fell to a bullet wound at Suvla Bay.

His friends, his colleagues at the Sydney University and at the Royal Prince Alfred Hospital, and his many acquaintances within the profession, mourn his loss. His youth, his bright, energetic and affectionate disposition, and his many sterling qualities have endeared him to many of us. While his fame is written in letters of blood in the annals of the war, his memory is graven in no less indelible letters in the hearts of those who had learned to know the man during the years of youth.

EDMUND OWEN.

The news of the death of Mr. Edmund Owen, F.R.C.S., LL.D., D.Sc., M.B., Consulting Surgeon to St. Mary's Hospital, London, will be received with deep regret by his many friends and former students. Mr. Owen had a cerebral hæmorrhage late in July, from which he died on July 23, 1915. He was 68 years of age. Mr. Owen was Surgeon-in-Chief to the St. John Ambulance Brigade, and within a few days of his death he was working at high pressure at the offices of the Order in Pall Mall.

As a surgeon, Mr. Owen was held in very high esteem, both by his colleagues and by the public. In addition to his office at St. Mary's Hospital, he was Surgeon to the French Hospital, and Consulting Surgeon to the Hospital for Sick Children, in Great Ormond Street. He held at various periods the Examinership in Surgery at the Universities of Durham, London and Cambridge, and was for many years a member of the Court of Examiners of the Royal College of England. His skill as a teacher was greatly enhanced by a most charming manner, which gained the affection, as well as respect, of all his students. He held the position of Member of the Council of the Royal College of Surgeons, and had filled the post of Vice-President a few years ago. Unlike the majority of his colleague on this body, he took an active interest in, and worked assiduously for the British Medical Association. For many years a Member of the Central Council of the Association, Mr. Edmund Owen so ingratiated himself with the other members that he was elected Chairman, and held this office until the Annual Meeting of the Association at Birmingham, in 1911, when Dr. James A. Macdonald was elected to follow him. Since that date he has been a Vice-President of the Association. During his term of office as Chairman of the Central Council, the fortunes of the medical profession were hanging in the balance, owing to the introduction of State Insurance. In connexion with this and with many other matters of medico-political importance, Mr. Owen exercised a keen insight into the matter at issue, a sound judgement as to the best policy to pursue, and a strict impartiality in dealing with the advocates of conflicting views. He held most tenaciously to the opinion that a man who called himself a consultant should limit his practice to consulting work. His support in the struggle between the Association and the group of quasi-consultants was of the greatest value to the former.

SAMUEL JABEZ RICHARDS.

Dr. Samuel Jabez Richards, whose death from pneumonia in Egypt was announced in our issue of August 21, 1915, was born in Dean, near Ballarat, Victoria, in 1863. After completing his general education he took up the work of

school teacher in Tasmania. He was one of the early students in the Medical School of the Sydney University, and obtained the degree of Bachelor of Medicine in the year 1893. Shortly after graduating, he was appointed Resident Medical Officer at the Royal Alexandra Hospital for Children, Camperdown, Sydney. In 1896 he took the degree of Master of Surgery. Prior to this he worked with Dr. Liddell at Maitland. In 1896 he left New South Wales for Queensland, and settled in Mount Morgan, where he built up an extensive practice. Dr. Richards held a commission in the Australian Army Medical Corps for a period of 10 or 11 years before the outbreak of war. He joined the first Expeditionary Force as Major, Second in Command, of the First Australian Clearing Hospital. On arrival in Egypt he became attached as Regimental Medical Officer to the 15th Light Horse, and was subsequently given command of the B Section of the First Army Medical Corps.

Dr. Richards was a man who commanded respect both within the profession and among his patients. He was a very capable practitioner, honest and straightforward, almost to a fault, and a highly resourceful man. The members of the Queensland Branch held him in high esteem.

Special Correspondence.

(From our London Correspondent.)

LONDON LETTER.

The Middlesex Hospital.

At a recent meeting of the Court of Governors of the Middlesex Hospital, it was reported that Prince Alexander of Teck had been re-elected Chairman, and Colonel the Hon. G. C. Gathorne-Hardy, Deputy-Chairman of the board for the year 1915-16. It was further stated that since the commencement of the war 301 soldiers of the Expeditionary Force had been treated at the hospital, and at the Clacton Branch, 1,432 wounded soldiers had received attention. The Branch Hospital had been equipped to deal with the most severe cases, and as one of three clearing hospitals for the Eastern Division it occupied an important place in the Army Medical Service for the district. The board had recently taken steps to establish a properly organized electro-cardiographic department for the scientific investigation of diseases of the heart. In respect of the Cancer Investigation Department there was little to report, the work having been reduced to the prosecution of researches which were of fundamental importance, and had been in progress for years.

In moving the adoption of the report, Sir Henry Morris, who occupied the chair, referred to the successful establishment of the Electro-cardiographic Department, instruments having now been devised for applying the measuring of electric currents to the human body, and detecting variations of the strength of the current produced by muscular action, and especially by the muscular action of each beat of the heart. It was now almost possible, in the opinion of those who had been working the instruments, to foretell from the action of the heart whether a person suffering from heart disease was likely to die suddenly or after a prolonged illness. Other important results would, no doubt, be obtained from the application of electro-magnetism to the human body. Alluding to the restriction of investigation work in the cancer department, he said all would agree that the object of everyone ought to be to apply themselves and their forces to securing a successful termination to the war. The Middlesex Hospital had from the first put aside to a certain extent other work in order to devote its energies to that purpose. That was shown by the large number of members of the staff and students—236—and of beds, and the material of the hospital, which had been placed at the disposal of the War Office and Admiralty. At the Clacton Branch all the beds, 130 in number, and at the hospital in London, 80 beds, had been put at the service of the military and naval authorities. All this was being done gratuitously, and the cost of the branch hospital alone was £6,000 a year.

Heart Surgery.

At the Academy of Medicine, of Paris, Dr. Beaussenat recorded, on May 4, 1915, a successful operation on the sub-

stance of the heart. The patient, a delicate man of 21 years of age, was wounded on October 1 by the bursting of a hand grenade, and a fragment of the projectile, three-fifths of an inch long, three-fifths of an inch wide, and an eighth of an inch in thickness, struck him in the heart. For four and a half months the fragment lodged in the right ventricle of the heart, lying free in the cavity. An operation was decided upon by Dr. Maurice Beausse, the head surgeon to the Asiles Nationaux, and the portion of the grenade was removed, and the heart sutured. There were three days of acute dyspnoea, followed by fever and lung complications, and on several occasions the patient nearly died from syncope.

During the operation the heart never stopped beating, and when the projectile had been removed the wound was successfully sewn up. Once convalescence was established, the patient made an uneventful recovery.

The General Medical Council.

The hundred and first session of the General Medical Council was opened in the Council's rooms in Oxford Street on June 1, 1915.

The chair was occupied by the President, Sir Donald MacAlister, Principal of Glasgow University, who pointed out, in the course of his inaugural address, that the call for qualified physicians and surgeons for duty with the army and navy had become more and more insistent with the progress of the war. He went on to say that our professional reserves have been drawn upon to the full, and that "throughout the Kingdom organized efforts are in progress for such readjustments of civil practice as will liberate all who can possibly be spared for the medical service of the navy and army. In these efforts the Scottish Emergency Committee and local committees of the British Medical Association, with the effective co-operation of members of the Medical Council, have taken a leading part. The services of qualified women have been freely offered and accepted for many of the places that are now vacant at home. Senior students enrolled in the combatant ranks have been recalled by the War Office, and directed to complete their curriculum with a view to qualification for the Royal Army Medical Corps. From overseas have come large numbers of our colonial colleagues, who are possessed of qualifications registerable in this country, and so are eligible for commissions in our army. By the opportune action of the Belgian Government and of the Privy Council, the Executive Committee was enabled to give effect to the application of Part II. of the Medical Act to Belgium, with the result that about sixty Belgian doctors of medicine have become legally qualified to practise in Britain, and to occupy professional positions in public and other institutions. From all these sources we have obtained timely and valuable help, but they must, if possible, be supplemented. If we are to make good the losses in the Army Medical Service we must accumulate larger reserves. The casualty lists, and, I am proud to tell, the lists also of awards for conspicuous gallantry, testify to the magnitude of these losses. We must endeavour to fill the vacant places by men whose training and skill can be guaranteed, and whose devotion is not inferior to that of their fallen comrades. We look with confidence to the medical schools and corporations to aid us in our endeavour to maintain, even in the present emergency, the standards of teaching, and of testing, which we regard as essential to efficiency."

Referring to the fact that able and efficient surgeons in Canada were desirous of coming to the aid of the Mother Country, but were hindered by difficulties connected with their local registration laws, Sir Donald MacAlister said that he had communicated with the various medical authorities concerned, and the response had exceeded all his expectations. From Ontario, British Columbia, Saskatchewan, Manitoba, and Alberta had come messages stating that legislation had already been initiated for the removal of existing provincial restrictions, and that the Provinces desired that reciprocity with this country might be established at the earliest possible date. When the necessary steps were completed, and he had reason to think that no obstacles need be apprehended on this side of the Atlantic, all the Provinces of Canada would have severally entered into reciprocal relations with the United Kingdom, the way

would be open for the application of the Medical Act to the Dominion as a whole, and the medical federation of the Empire would be accomplished.

The Council confirmed the resolution of the Executive Committee, declaring that so long as the Order in Council of January 7, 1915, remained in force, any person who produced evidence to the Registrar that he had obtained the degree of Doctor of Medicine in the Belgian Universities of Brussels, Ghent, Liège, and Louvain, and was legally authorized to practise medicine, surgery, and midwifery in Belgium, should be entitled to be registered in the foreign list of the Medical Registrar.

A similar resolution relative to Belgian dental practitioners being registered on the Dentists' Register was confirmed.

The Finance Committee's report was considered, and accepted. The Council then dealt with the reports of the Dental Committee in regard to irregular practice on the part of certain dental practitioners.

The whole of the second and the greater part of the third day's sittings were concerned with the consideration of penal charges against medical practitioners. Reports were received and considered from the various Committees of the Council. The Committees were reconstituted for the ensuing year. On the motion of Dr. Norman Moore, seconded by Sir Henry Morris, Major Norman C. King was reappointed Registrar.

On June 4 one penal case was investigated, and the remaining Committee reports were discussed and adopted. The session then came to a conclusion, after a cordial vote of thanks had been passed to the President for his services in the chair.

Correspondence.

INFECTION IN CAMPS.

Sir,—The morbidity and mortality from infectious disorders attending the concentration of recruits in camps in Australia is so serious and so deplorable that one is constrained to ask what measures are being taken to minimize the evil. It is sad in the extreme to hear of or to know of men who have nobly realized their duty dying of cerebro-spinal meningitis within a few days of taking the King's shilling. As far as one can gather, the measures taken are more or less of a curative nature; that is, when a man is sick he is placed in a hospital. The preventive measures are confined to vaccination and swabbing throats of men in camp to detect carriers.

For influenza, pneumonia, acute rheumatism and measles nothing is done, or at least effectively done to prevent their spread. Of course, one can say such unfortunate contingencies are inseparable from camps containing anything up to and over 5,000 men, who are regularly visited by hosts of friends and relations, of whom a high proportion are at present the victims of epidemic diseases, either incubating or defervescing.

To make some suggestions of a preventive nature, let us give due weight to the cult of the previous case in epidemiology, and regard the recruit as being on active service the moment he is drafted to a camp, and let acting service conditions prevail. It is hard, even cruel, but it is kind.

Put an end to all visits from friends and "camp followers." Stop all leave. Institute all possible forms of recreation and any kind of canteen (wet or dry).

All recruits to be first admitted to an observation camp, and only drafted in to the main camps when the medical officer is satisfied that each one is not incubating or carrying any infection. If illness develops, however slight, removal to hospital to be ordered at once.

For many years I have followed the cult of the previous case, and have relegated so-called "insanitary conditions" to a very secondary place and to the sentimentalist. Flies, fleas, mosquitoes, bugs, *et hoc genus omni*, are yet only insects in the absence of the previous case.

*Stegomyia fasciata** has no meaning to us yet. There is no "previous case."

Yours, etc.,

A. C. F. HALFORD, M.D., Ch.B. (M.), M.D. (Q.).
Brisbane, September 4, 1915.

* Relation to dengue not admitted.

Medical Appointments.

Dr. C. L. Handcock has been appointed Government Medical Officer at Muswellbrook, New South Wales, in place of Dr. F. H. May (resigned).

Dr. Arthur Ellis Blythman has been appointed Government Medical Officer at Boggabri, New South Wales.

Dr. A. Sandison has been appointed Senior Resident Medical Officer at the District Hospital, Ballarat, Victoria.

Dr. Sinclair Gillies, of Sydney, New South Wales, has been appointed a member of the Police Medical Board during the absence on military service of Dr. Charles MacLaurin.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xi

Brisbane Hospital, Resident Medical Officers.
Children's Hospital, Perth, Resident Medical Officer.
Lunacy Department, Victoria, Medical Officer.
Queenstown Hospital, Mount Lyell District, Medical Officer.
Bundarra District Hospital, Medical Officer.

Books Received.

LECTURES ON ELEMENTARY ANATOMY AND PHYSIOLOGY, INCLUDING SHORT SKETCHES OF BIOLOGY, EMBRYOLOGY AND COMPARATIVE ANATOMY, by H. Clifford Barclay, M.D., Ch.B., F.R.C.S.E., M.R.C.S., L.R.C.P.; Second Edition, 1915. London: Baillière, Tindall & Cox; demi svo., pp. 281, with 22 illustrations. Price, 6s. net.

MEDICINE AND MEDITATION: OCCASIONAL WRITING, by Alex. Lewers, M.R.C.S., L.R.C.P., D.P.H., 1915. Melbourne: Ford & Son; demi svo., pp. 127. Price, 3s. 6d.

THE PRACTICAL MEDICINE SERIES, VOL. IV., GYNÆCOLOGY, under the general Editorial Charge of Charles L. Mix, A.M., M.D.; edited by Emilus C. Dudley, A.M., M.D., and Herbert M. Stowe, M.D. Series 1913. Chicago: The Year Book Publishers. Demy svo., pp. 234. Price, 6s. 6d.

DISEASES OF THE ARTERIES, INCLUDING ANGINA PECTORIS, by Sir Clifford Allbutt, K.C.B., M.A., M.D., F.R.C.P., F.R.S., Hon. M.D., I.L.D., D.Sc., in two volumes, Vol. I-II, 1915. Macmillan & Co., Ltd.; Demy svo., pp. 334 and 359 respectively. Price, 30s. net.

JOURNAL AND PROCEEDINGS OF THE ROYAL SOCIETY OF NEW SOUTH WALES, Vol. XLIX, Part I; Demy svo., pp. 144, with 12 plates, containing Papers read in May and July (in part), 1915. Sydney: George Robertson & Co. Pty., Ltd.

Diary for the Month.

- Sept. 14.—Tasmanian Branch, B.M.A., Monthly and Council.
Sept. 15.—West. Aust. Branch, B.M.A., General.
Sept. 17.—Queensland Branch, B.M.A., Council.
Sept. 21.—N.S.W. Branch B.M.A., Executive and Finance Committee; Ethics Committee.
Sept. 23.—Return of Ballot Papers for election of two members of Federal Committee.
Sept. 24.—Melb. Hosp. Clinical Soc.
Sept. 24.—N.S.W. Branch, B.M.A., Ordinary. Election of two members of Federal Committee.
Sept. 28.—N.S.W. Organization and Science Committee; Medical Politics Committee.
Sept. 28.—Vict. Branch, B.M.A., Eye and Ear Section.
Sept. 29.—Vict. Branch, B.M.A., Council.
Sept. 30.—Vict. Branch, B.M.A., Election of two members Federal Committee.
Sept. 30.—South Aust. Branch, B.M.A., Monthly.
Oct. 1 and 2.—N.S.W. Branch, B.M.A., Annual Meeting (1915) of Delegates of Local Associations of Members with the Council.
Oct. 1.—Q. Branch, B.M.A., Monthly.
Oct. 5.—N.S.W. Branch, B.M.A., Council (Quarterly).
Oct. 6.—Vic. Branch, B.M.A., Monthly.
Oct. 8.—N.S.W. Branch, B.M.A., Clinical.
Oct. 8.—S. Aust. Branch, B.M.A., Council.

Covers for binding *The Medical Journal of Australia* for Vol. I, 1915, can be obtained on application to the Manager B.M.A. Building, 30-34 Elizabeth Street, Sydney. The price of a cloth cover is 2s., and of half leather 3s. 6d.; postage, 7d.

Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane).	Brisbane United F.S. Institute. F.S. Lodges at Longreach.
WESTERN AUSTRALIA. (Hon. Sec. 230 St. George's Terrace, Perth).	Swan District Medical Officer. All Contract Practice Appointments in W.A.
NEW SOUTH WALES. (Hon. Sec. 30-34 Elizabeth Street, Sydney).	Australian Natives Association. Balmain United F.S. Dispensary. Burwood District F.S. Institute. Canterbury United F.S. Dispensary. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Mullumbimby District Friendly Societies. N.S.W. Ambulance Association and Transport Brigade. N. Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Braidwood. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Mudgee. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, and Auburn. F.S. Lodges at Wellington. Newcastle Collieries—Killingworth. Seaham Nos. 1 and 2. West Wallsend.
SOUTH AUSTRALIA. (Hon. Sec. 3 North Terrace, Adelaide).	The F.S. Medical Assoc. Incorp., Adelaide.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

The Librarian of the New South Wales Branch has called our attention to the fact that the following issues of the *Lancet* have been borrowed some time ago, and have not yet been returned. The member who has these copies in his possession is respectfully requested to return the same as soon as possible, in order that the volume may be bound: January 2, 9, 16, 23, 30, February 6, 13, 20, April 24, and May 29.

The Librarian of the Victorian Branch will be pleased if any member possessing spare copies of the following journals will present them to the library, in order to complete the sets:—

Lancet, October 3, 1914, April 10, 1915, and subsequent numbers.
Practitioner, September to December, 1914, January and February, 1915.